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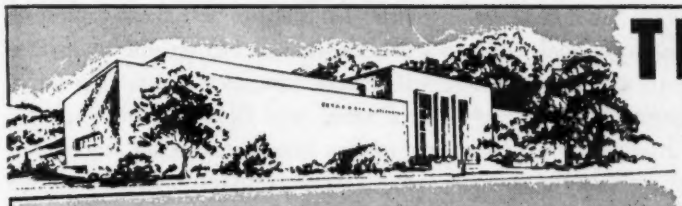

TEXAS State Journal of Medicine

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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TEXAS STATE JOURNAL OF MEDICINE, 1905—

With this issue the TEXAS STATE JOURNAL OF MEDICINE embarks on its fifty-first year of continuous monthly publication. It was deemed appropriate on this golden anniversary to return briefly to July, 1905, and recall the circumstances which led to the first JOURNAL, to reflect on the progress which medicine as a whole and the medical profession in Texas in particular has achieved this half century, to bring readers behind the scenes for a moment to help them understand what goes into the finished periodical, and to pay tribute to the vision, ability, and energy of those who were the mainstay of the JOURNAL through most of its first fifty years.

The "horse and buggy" doctor on the cover is the sort of doctor loved by Texas patients back when the JOURNAL began. We hope you will read the article summarizing the medical and surgical strides that have occurred during the life of the JOURNAL. We hope you will refer to the items in the Library and Auxiliary sections telling of other Texas publications and to the column at the end of the Editorials quoting from the JOURNAL fifty years ago. We hope that you will turn to the pages immediately following the Original Articles and refresh your minds as to the past of the JOURNAL and perhaps learn a few facts about its present. Especially, we hope this material pleases you.

There is always a desire when an anniversary is celebrated to reminisce nostalgically and to paint a heroic picture of past success and achievement. The antidote for this undoubtedly pleasant but not entirely profitable tendency is to look back only long enough to understand why we are where we are and to observe attitudes and actions which, if translated to present needs, will be constructive. Then it is sensible to look ahead and move into the future.

Medicine is not static. Laboratory and clinical discoveries seem to unfold as regularly as

days on the calendar. The needs of patients, living in a mechanized age beset with political and social problems, are not those of the generation before. The climate of opinion surrounding the doctor and his work is transitory, though at any moment in time it may seem as binding as bands of steel. The medical profession has found answers to many problems and has the virility and stamina to find many more. This JOURNAL is ready to help in this search and to record the steps Texas doctors take in the road ahead.

But the JOURNAL is not an independent entity. It is the eyes and ears, the tongue, the hands of 7,000 members of the Texas Medical Association; without them it is a shadow. As the first editorial fifty years ago said: "This JOURNAL is owned and controlled by the medical profession. The use each member makes of it will determine its value and usefulness. The support of every Texas physician is solicited."

With the interest and support of members of the Association to which it belongs and with God's help, the TEXAS STATE JOURNAL OF MEDICINE can look to a future in which it will be a credit to the medical profession and a boon to the people who turn to that profession for health care.

LEGISLATIVE ACTION

The effectiveness of "grass roots" activity in the field of legislation is evident once again after a review of accomplishments of the medical profession during the recent session of the State Legislature.

State Senators and Representatives have an open ear for the people back home in their districts. Letters and telegrams from constituents are welcomed and usually are given due consideration.

Physicians and their wives throughout the state made two major efforts during the past session of the Legislature, and their communications were not in vain. Legislation was passed which will restore competition among companies which write professional liability or so-called malpractice insurance. In addition, a bill which would have completely legalized the practice of naturopathy was permitted to die without enactment.

The legislative spotlight has now been shifted to Washington where the eighty-fourth session of Congress is entering the "home stretch." Legislation of definite interest to the medical profession includes such issues as the Salk poliomyelitis vaccine, federal aid to medical education, changes in the social security program, and authorization of tax-deferred funds enabling the self-employed to establish voluntary pension programs. These important issues and many others will be aired within the next few weeks.

Contrary to the criticism that organized medicine takes a negative stand on any new idea is the record of health legislation in the eighty-third session of Congress. Organized medicine supported 11 of 15 major medical bills which were enacted into law, took no definite stand on 2 others, and opposed only 2.

Evidence of what can be achieved by individual support may be noted in the results of these two major issues opposed by organized medicine. When the matter of including physicians under social security on a compulsory basis came before the eighty-third Congress, the medical profession sounded the alarm. Texas physicians and their wives, acting as individuals, flooded their Congressmen with 4,200 telegrams, telephone calls, and letters within a period of 48 hours. As a result of this sort of interest, Congress reconsidered the original action and deleted physicians from coverage under the bill. This has saved Texas doctors an estimated $890,000 a year. Congress also listened to the people back home when the

federal reinsurance bill was considered by the House of Representatives last July, and the legislation was defeated by a two to one majority, with 20 of 21 Texas Representatives voting with the medical profession and against federal reinsurance.

The medical profession again has taken a positive position on legislation now pending in the eighty-fourth Congress. The AMA has commended President Eisenhower on his special health message to Congress. It has pledged continued support to improve the health of the nation by strengthening medical efforts at the state and local levels.

Details of legislation pending in Washington and of recent state legislative action of particular interest to physicians may be found in the news section of this JOURNAL on page 485. Physicians and their wives should take advantage of the opportunity to study the legislative situation and to express opinions to their elected representatives.

PR CONFERENCE

Plans for the Texas Medical Association's first annual public relations conference, to be held September 10 in Austin, are near completion. This conference, tailored to fit the needs of public relations workers at the county level, is the first attempt by the State Association to bring local chairmen together for a program especially designed for them.

Similar programs have been effective on a national level scaled to coordinate the activities of state associations. Other states have initiated PR conferences for their local chairmen which have met with success. Expert advice and guidance have helped county societies to promote special projects and gain the goodwill of their communities.

Members of the Committee on Public Relations, headed by Dr. William M. Crawford, Fort Worth, will be hosts at the conference. Mr. Leo Brown, Chicago, director of public relations for the American Medical Association, will speak on "Public Relations and Its Application to Medicine." Of particular interest to county chairmen will be a panel discussion on "PR Programming for County Societies." Mr. John Bach, director of press relations for the AMA, will tell how the doctor and the county society can work toward good relations with the local press. In this panel public grievance committees will be discussed, as will internal and external public relations programs. Topics relating to internal public relations programs will include indoctrination of county society members, providing medical care for all, the business side of medical practice, and the importance, public relations–wise, of the medical assistant. In the discussion of external programs health forums, health fairs and exhibits, commemorative programs, emergency call systems, and public service projects will be considered.

One of the newest of public information mediums, television, will be the subject of a panel discussion, during which the doctors will learn how television can be made to apply to medicine. Television also will be discussed from the standpoint of its value as a new public relations tool, and doctors will be given information about putting a show on the air.

Held on the same weekend as the Executive Council meeting, the conference will provide an opportunity for a doubly profitable visit to Austin.

AUXILIARY TRANSACTIONS

The transactions of the thirty-seventh annual session of the Woman's Auxiliary to the Texas Medical Association and the Auxiliary membership list will appear in the August JOURNAL. Publication has been postponed to make room for the special anniversary section which appears in this issue. The JOURNAL staff wishes to thank Auxiliary officials for their cooperation.

50 Years Ago

(Excerpts from the July, 1905, issue of the Journal.)

"On the opening morning (of the 1905 annual session in Houston) . . . Dr. Red (S. C., deceased, Houston), for the Committee on Arrangements, told us how many kinds of a good time we were going to have. . . . President Daniel (F. E., deceased, Austin) told me he was fearful of a frost. I was fanning at the time; it didn't feel like it to me. He said he meant as regards an audience at the President's Address. He was disappointed. There was a very large audience to greet him at the close of his able administration. . . . I dropped into the House of Delegates. Poor fellows, they worked all the time—hardly heard a paper."

Under the heading "Fifth, or San Antonio, District Notes" was this, "Medina County Society is unable to report any increase in membership, since there are no eligible physicians in the county who are not already members."

It was suggested that "The society scrap-book is worthy a trial in most societies. The term 'scrap' does not refer to the proceedings of the society, but to press notices which the county secretary clips from the daily papers and pastes in a book. Members may preserve their reputations, by timely explanations under the notices. Selected readings from such a book have often been found rich, rare and racy, usually accompanied by much mirth and to do more toward reformation than threats, preferred charges or society discipline."

From an advertisement for the Medical Department of the Tulane University of Louisiana comes "Founded in 1834, this is the oldest Medical College in the Southwest and has 4,174 graduates and, at the last session, 496 students. . . . The fees for the first and second year will amount to a total of $135 for each year. The total of the fees for the four courses will amount to about $585."

"Rates for board and nursing are from $1.50 to $4.00 per day" at the Physicians and Surgeons Hospital, San Antonio, according to the cover advertisement in the first issue.

It was noted that July 1, 1905, also was the birthday of *Surgery, Gynecology and Obstetrics*, the "magazine of surgery." ". . . This staff is one of the strongest in medical journalism. Its editorial policy aims at the highest scientific standard. It is published by a stock company composed of Chicago physicians. We extend our best wishes to this sturdy fellow infant."

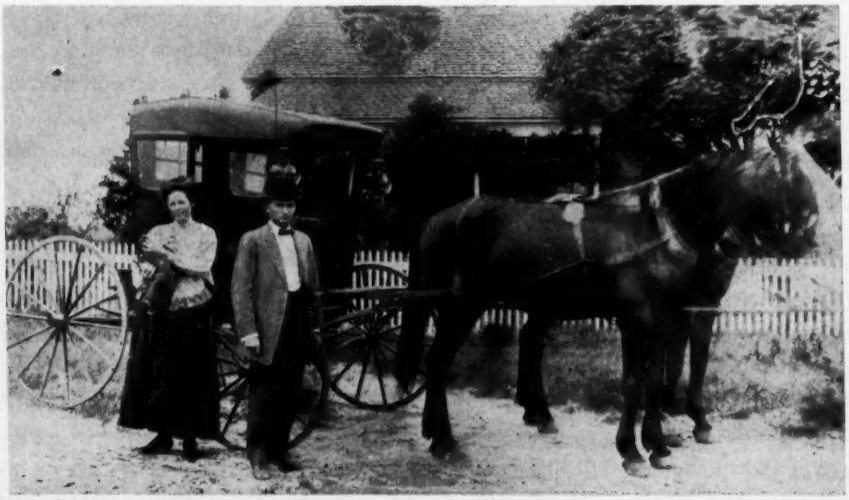
Dr. A. C. Scott of Temple read before the Section on Surgery at its 1905 session in Houston a paper on intestinal anastomosis by intra-intestinal ligature and rapid suture forceps, which was printed in the first JOURNAL. Attention was called to the original article in an editorial: "We are glad to publish in our first issue such a valuable contribution to intestinal surgery as the Scott needle for the rapid closure of the ends of the divided intestine in lateral anastomosis. It marks a distinct advance and we believe will be widely used."

"State News" was the heading for such items as examination questions given by the Board of Medical Examiners for the State of Texas, Austin, Texas, May 2, 3, and 4, 1905; the announcement of the convention of health officers, other state meetings, and graduation exercises at the University of Texas; and background information on a bill to establish a "Physio-Medical State Examining Board."

"The smallpox epidemic in Texas is diminishing in virulence. The death rate is very low. Quarantine is rarely necessary. Vaccination is sufficient to control the disease in nearly every case. Texas is greatly in need of a compulsory vaccination law on her statutes."

"Boston, in his next edition of Clinical Diagnosis (to be out within two months), will use the plates of zygotes of the malarial parasite, published in the 1904 volume of Texas State Transactions, by Dr. Albert Woldert of Tyler."

A good suggestion any time: "Attention, Members!—In this issue is published a complete official roll of all members in good standing in the State Medical Association of Texas, with their addresses. Errors in this list should at once be reported to the editorial office to insure delivery of the Journal."



Ready for a Sunday outing in April, 1910, are the R. W. Holtons of Terrell. This buggy and team was said to have been the best equipment for a country doctor in Kaufman County on that date. Dr. Holton is the General Practitioner of the Year 1955 in Texas.

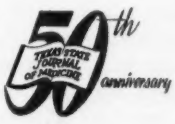
ORIGINAL ARTICLES

MEDICAL AND SURGICAL PROGRESS 1905-1955

T. H. THOMASON, M. D., F.A.C.S., Fort Worth, Texas

"Yet I doubt not through the ages one increasing purpose runs,
And the thoughts of men are widened with the process of the suns."
—Alfred Tennyson.

IN THE 50 years that have encompassed the life of the TEXAS STATE JOURNAL OF MEDICINE there has been more progress in medicine and in surgery than had been recorded in the previous 2,000 years. In 15 of those 20 centuries medical men floundered in the abyss of ignorance and superstition. As the light of the Renaissance began to dawn Andreas Vesalius—in his *De corporis humani fabrica*—showed surgeons where to cut. Ambroise Paré, inventor of the ligature, showed them how to control hemorrhage. William Harvey (1628) demonstrated the circulation of the blood. Edward Jenner (1796) gave the world smallpox vaccination. Pasteur discovered germs. Lister showed surgeons how to be clean. Crawford W. Long and James Y. Simpson with ether and chloroform conquered pain. Holmes and Semmelweiss demonstrated the cause of childbed fever, and Walter Reed (1900) solved the problem of "Yellow Jack."



MEDICINE

By 1905, natal year of the JOURNAL and beginning of this narrative, Dr. William H. Welch had brought back to America the best ideas to be gleaned from the leading medical minds of Europe, and the modern clinical and pathological laboratory was well on its way. Dr. Welch, more than any one individual, sparked the golden age of medical discovery that was to follow. He was to live another 30 years and to extend his influence through many brilliant pupils to every important medical center in America. Dr. Howard A. Kelley had fathered the specialty of gynecology. Dr. William S. Halsted—he of the rubber gloves and the silk suture—was teaching the philosophy of the gentle and meticulous handling of tissues and the perfect healing of wounds. One of his pupils, Harvey Cushing, was already embarked on the special work which led him to be known as the father of neurosurgery. Dr. William Osler, greatest clinician of his day, had written his "Principles and Practice of Medicine" and had made his real contribution in the art of bedside teaching. So much for the background; the stage was set for an era of medical progress far surpassing any that had gone before.

Osler spoke dramatically of the Men of Death—those cohorts of disease against whom we doctors strive and will continue to strive until the end of time. There are not so many of them now, but in 1905 their name was legion. Captain of the Men of Death was Pneumonia. He was to retain his rank and to baffle all efforts to curb his ravages for another 30 years. He took terrific toll of soldiers and civilians in 1918-1919 before falling to the superior forces of chemotherapy (the sulfonamides) in 1935. He was also called the "friend of the aged" who, deprived of his kindly ministrations, linger on and on in the sandy deltas of senility and, like Tithonus, lack the power to die.

Foremost in the ranks of Osler's Men of Death stood Tuberculosis, known also as the Great White Plague. In 1905 he was "facile princeps" among the causes of death in this country. He was greatly reduced in succeeding decades by preventive measures, health education, and finally by streptomycin. Though restrained, he remains a potential menace that must always be guarded. A very significant news item of recent date is the closure of the famous Trudeau Sanitarium.

Syphilis at the turn of the century was a great killer of the newborn and a cause of more unhappiness and human misery than any other disease. Medical students of that day were all familiar with the famous dictum "To know syphilis is to know medicine." In 1905 the Treponema pallidum was discovered to be the cause of this plague. In 1906 came the famous Wassermann test, to be incorporated 30 years later into the hospital routine the world over. In 1909 Paul Ehrlich, real father of chemotherapy, announced the discovery of salvarsan, and the effectiveness of the fight against syphilis was greatly increased. It was still to play terrific havoc with armed forces engaged in World War I, and as late as 1935 approximately 10 per cent of our population had the disease. Penicillin, in general use a few years later, proved to be an effective weapon in the fight

against syphilis, and so was administered the coup de grace to one of mankind's greatest enemies. The younger generation of doctors will see little of tabetic crises, charcot joints, luetic aortitis, and Hutchinson's teeth.

Hand in hand with syphilis went another venereal disease—gonorrhea—source of tremendous disability, morbidity, and unhappiness among the young and vigorous, scourge and blight of armies, inhibitor of populations, and greatest cause of infant blindness. Gonorrhea was to flourish and exact its toll of human misery until the advent of the sulfonamides in the late thirties brought it low. Many of us recall the weeks of bed rest and careful nursing required to bring under control a case of acute salpingitis, and certain of us cut our surgical eye teeth on laparotomies for chronic pelvic inflammatory disease. Sulfa and penicillin ended all this. In World War II casualties due to the gram-negative Diplococcus were negligible, and in the past 15 years salpingitis has practically ceased to be a surgical disease.

Sixth in line as a cause of death in 1905 was diarrhea and enteritis of infants with a mortality of 19.6 per 1,000. Thanks to the development of the science of pediatrics and to the compulsory pasteurization of milk (1914) and to the antibiotics, this mortality rate fell gradually to .4 per 1,000 in 1949, and is still lower in 1955. Such was also the fate of typhoid fever, tenth in rank of the Men of Death in 1905 and now seldom seen in any land where modern sanitation has control. In children the mortality of contagious diseases has been reduced in 50 years to less than 3 per cent of its former rate. Main cause of death in children over 1 year has come to be accident and cancer.

The limitations of this article permit the mention of only a few of the milestones of medical progress which have been turned in the past half century. Some of these follow:

The conquest of hookworm disease beginning in 1910.

The victory over pellagra and rickets.

The successful fight on typhus and the rickettsial diseases.

The introduction of vitamin therapy in deficiency states.

The isolation of thyroxin in 1914 by Kendall.

The discovery of the use of iodine in thyroid disease (Plummer 1923).

The discovery of insulin by Banting and Best in 1920.

The discovery of the use of liver extract in pernicious anemia by Whipple and others in 1928.

The use of intravenous medication and fluid replacement (early thirties).

The citrate method of transfusion and the rise of blood banks.

The discovery of sulfanilamide by Domagk in 1935.

The use of oxygen in the treatment of anoxia.

The control of malaria.

The discovery of penicillin by Fleming in 1928 and its application by Florey in 1938.

The "miracle drugs" ACTH, cortisone, and the host of antibiotics.

The control of hypertension by drugs, of ulcer by Banthine, and so forth.

Convulsive therapy in the psychoses, Thorazine, reserpine.

Immunization (active) against typhoid, diphtheria, tetanus, poliomyelitis.

The Rh principle in erythroblastosis fetalis.

SURGERY

So much for progress in medicine during the life of our STATE JOURNAL. What about the widening of surgical thought during that period? Surgery by the turn of the century had undergone great development made possible by the work of Lister in antisepsis and by the discovery of ether anesthesia. Extensive procedures such as thyroidectomy, radical mastectomy, gastroenterostomy and gastrectomy, cholecystectomy, hysterectomy, and removal of the vermiform appendix were carried out with a high degree of rapidity and skill and a pardonable mortality. Main surgical specialties were coming into being by 1905. But surgery was stymied by the limits of anesthesia, by the paucity of means of combating shock, by the inability to replace blood loss, and by its failure to control infection. So, while medicine forged ahead with victory upon victory over disease, surgery waited and perfected its technique.

The synthesis of Novocain by Einhorn in 1905 was an epoch making addition to the surgical armamentarium not fully appreciated until many years later. Plastic surgery, fostered by Blair, Staige, Davis, and Gillis, developed rapidly under the stimulus of World War I, as did also orthopedic surgery. Techniques of diagnosis and surgery of lesions of the brain and spinal cord became much more accurate. Myelography was developed. The cholecystogram greatly simplified the diagnosis of gallbladder disease. X-ray examination of the gastrointestinal tract reached new heights of accuracy. The intravenous pyelogram was one of the greatest blessings ever bestowed upon suffering mankind. The Wangensteen principle of intestinal decompression profoundly mitigated the postoperative horrors of abdominal surgery. The discovery of the use of Lugol's solution in cooling down toxic goiter in preparation for thyroidectomy was a great factor for safety in the management of Graves'

disease. This was augmented by the perfection of the antithyroid drugs, which have relegated the once dreaded thyroid crisis to the bad dreams of other days. The improved technique of transurethral resection in 1930 was a godsend to aging males with prostatic obstruction.

It is all too true that important discoveries may sometimes lie dormant for years until someone comes along who can grasp their real meaning and correlate long known facts into practical application of great value. Fleming discovered penicillin in 1928, but a decade was to pass before Florey in 1938 applied it to the treatment of infection. The citrate method of transfusion of blood was known in 1911 and was used after 1915, but it was not until 1930 that Blalock showed how to combat shock with blood replacement; and it took the tragic demands of World War II ten years later to disseminate this information. Blood banks came into being in response to the increased demand for blood. The anesthetics in common use today were known for many years. The endotracheal tube was evolved for use in anesthesia by Macewen in 1880. The principle of positive pressure in anesthesia was perfected in 1909. The closed system of anesthesia with the addition of oxygen and the removal of carbon dioxide to permit rebreathing was worked out in 1915. Another 25 years were to pass before the present controlled type of anesthesia became generally available.

By 1940 blood was to be had for the control of shock; anesthesia was adequate as never before; penicillin and the antibiotics were available to combat infection. The stage was set for the advent of thoracic surgery. In 1933 Graham performed the first successful one-stage pneumonectomy for cancer of the lung. In 1939 Gross did the first operation for patent ductus arteriosus. In 1944 Blalock performed the now famous "blue baby" operation for the tetralogy of Fallot, and Crafoord and Gross operated successfully for coarctation of the aorta. In 1947 Bailey and Harken pioneered commissurotomy and valvuloplasty for mitral stenosis. Latest surgical triumph has been the work of Cooley and DeBakey on the resection of aortic aneurysm and restoration of the aorta by grafts or prostheses. Anesthesiologists, advancing to meet this challenge, have come up with hibernation and hypotensive anesthesia.

MILITARY MEDICINE

This story would not be complete without mention of the triumphs achieved in military medicine in the period under review. World War I was the first war in history in which combat casualties exceeded those caused by disease. Care of the wounded was a brilliant record in World War II. And in the Korean War, thanks to modern methods of transportation and to modern medical treatment, the salvage of the wounded reached the unprecedented high of 97.5 per cent.

PRESENT AND FUTURE

With the control of infectious diseases and the great reduction in infant mortality these 50 years have seen the average span of human life increased from 47 to 68 years. In an aging population which must pass on in some way, the degenerative diseases —heart disease and cancer—have assumed first and second place as a means of exit from this mundane existence. Great strides have been made in the diagnosis and treatment of heart disease. In cancer the education of doctors and public in the past ten years has resulted in earlier recognition and earlier treatment, which stems but hardly lessens the mounting tide of malignant disease. Massive and heroic measures are often undertaken in the effort to extirpate advanced cancer, with sometimes questionable regard for the comfort or effectiveness of the patient who survives such surgery. Age is no barrier to major surgery; the old folks tolerate with equanimity and fortitude the most formidable operations for a few more months or years of grace.

In 1905 Texas doctors were yet in the saddlebag era. The age of empiricism was ending, the age of exact knowledge was beginning. They were long on the art of medicine in those days and short on the science. In 1955 they are much longer on the science and sometimes a bit short on the art. There has been much nostalgic drivel about the passing of the family doctor, who really has not passed at all but exists today in the person of any doctor—specialist or not —who inspires patients with confidence in his wisdom and judgment.

To predict the future of medicine and surgery in the next 50 years would be as futile as it was half a century ago. Main problems of the years ahead will be the control of heart disease and cancer in the effort not only to prolong life but to provide escape from it pleasantly, and with longer life of the body to insure longer life of the mind, lest too many of our aged vegetate in a state of expensive oblivion, among the unburied dead, "Sans teeth, sans eyes, sans taste, sans everything."

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1226 Pennsylvania, Fort Worth 4.

MEDICINE IN AN INDUSTRIAL CIVILIZATION

WALTER B. MARTIN, M. D., Norfolk, Virginia

DR. WALTER B. MARTIN, *President of the American Medical Association, was one of the special speakers at the 1955 Annual Session of the Texas Medical Association in Fort Worth. This paper was presented at a general meeting, April 25.*

I HAVE often thought of medicine as being supported by four great pillars: research, education, prevention, and practice. In addition to these four great divisions, I believe there is a fifth that is as important and possibly more important than all the others in its effect on the body of medicine, and that is the environment of medicine. This environment of medicine is changing profoundly as we move from a rural and agrarian community into an industrial society.

We are being pressed upon now by many groups, organized labor, political groups, government, and social organizations, so that medicine is now under fire and under pressure during this transition in the form of our civilization. The framework within which medicine is practiced has undergone great changes also. As a boy I lived in the country near a small village in the mountains of Virginia, and medicine was much different then. Those were the days when the doctor on horseback carried his total equipment of drugs and instruments in his saddle-bag and dispensed his own medicine. He was kind and gentle, and knew all about his patients, their families, and their various illnesses as they were growing up. At the turn of the century, medicine was short on science and long on art. Perhaps the pendulum has now swung too far the other way. Then the physician was honored and loved. He, together with the minister, the school teacher, and the judge, represented health, morals, knowledge, and justice. They really dominated community thought, and they influenced and directed community life.

We have seen in our time the development of two great forces, the industrial revolution and the revolution in medicine. The steel furnaces of the world have been fanned to a white heat by the winds of two great wars and by the threat of a third. This forced draft has crowded into less than half a century an industrial development greater in volume than that of all the past ages. The surging energy of a pioneering people has swept across the great plains and beat upon the Pacific and has now been directed into industrial development. It has brought about great changes in our way of life and in our social and political thinking. The development of great industrial centers and the retreat from the farm has changed us from a rural to an urban nation, but our social and political thinking has not kept abreast of our roaring industrialism. We have developed instruments of war capable of destroying our civilizaton, but we have not developed a moral sense or a science of government that is capable of controlling them. A democracy planned for an agricultural people is constantly pressed to make it work in an industrial society.

MEDICAL REVOLUTION

No less is the problem that medicine faces as a result of the medical revolution. Great advances in medicine during the past half century have changed the framework in which medicine is practiced. The machinery of medicine has outgrown the little black bag; it now must be housed in great institutions and hospitals and administered by boards of trustees, usually laymen. The physician, like the artisan of a century ago, has lost possession of his tools.

The last half century has seen profound changes in medicine, in medical research, in teaching, and in the application of medicine to the prevention and treatment of disease.

The progress of medicine during this time is exemplified by the great lowering in infant and maternity mortality, by the control of infectious diseases, and by a greatly lengthened span of human life. The very success of medicine has changed the pattern of medicine radically, but the burden and responsibility of medicine have not lessened. The decrease in the acute communicable diseases has been paralleled by an increase of chronic conditions and the degenerative diseases characteristic of the older age group.

HOSPITAL EXPANSION

These great changes in the science of medicine and their application to the diagnosis and treatment of disease and disabilities have necessarily been reflected in the corresponding expansion of hospital facilities and services. In the past 20 years, the population of our voluntary hospitals has multiplied more than three times. This increase has been necessary because the special equipment, laboratories, and other ancillary units so important in the practice of modern

medicine are centralized in the hospital. To operate this machinery of medicine, highly trained technicians are required. The cost of construction and maintenance of the modern hospital has increased to what would have seemed fantastic a generation ago. Labor cost has increased, not only in proportion to the general wage increase, but in relation to the overall number of employees per patient. The total increase in the cost of operation of a hospital over a period of 15 or 16 years is nearly 700 per cent. The cost of the labor part alone is nearly two-thirds of the cost of operating hospitals. Much of the increase is in the field of the highly skilled and trained group of technicians who operate the machinery of modern medicine. That increase is going on all the time as more and more instruments of precision and more complicated methods of procedures are introduced into the hospitals.

In many areas this has brought the hospital face to face with the problem of hospital financing. According to the study made by the Commission on the Financing of Hospital Care, the voluntary hospitals in this country in 1953 were behind at the end of the year to the extent of $141,000,000. Their problem is finding the funds for construction, expansion, and replacement; keeping their equipment in order; and expanding into new fields of service as advances in medicine place upon them the burden of making these new procedures available to patients.

It is well for the people in every community to remember that the voluntary hospitals make no profit and declare no dividends. Their boards of trustees render a difficult service without pay and often without recognition for the great contribution they make to community welfare. It is well, also, for people to remember that they will receive the quality of hospital care that they want badly enough to pay for, and that insufficient total hospital income will be reflected in a lowering of the quality and quantity of hospital and medical services available to all.

It is also true that with an increase in per diem cost to the patient for hospital care, many persons are faced with the problem of how to meet the bill. Illnesses, as far as most people are concerned, are unpredictable as to the time of occurrence, severity, and duration. Unprepared persons may not be able to meet the cost in whole or in part; this is particularly true in periods of economic depression. I want to point out, however, that although the daily cost of hospital care has risen sharply, improved methods of treatment, better equipment, and better operating techniques have sent the average days of hospital care for patients into a rapid decline. The average stay in the hospital has now reached an all time low of about seven days, on the average throughout the country, and that is just about half of what it was 15 to 18 years ago.

Out of this dilemma came the first plans for volunteer prepayment of the cost of hospital care; later, for the prepayment of the cost of surgical and medical care in hospitals. By 1939, nine million people had voluntary plans for the prepayment of hospital care. By the end of 1954, the number had increased to more than one hundred million, with more than eighty-five million covered against surgical cost in hospitals and more than forty-five million insured against the cost of medical care in hospitals. This extraordinary growth is continuing, and there is a reasonable hope that in a few more years nearly all of the insurable risks in this country will be protected. The double benefits from voluntary coverage are obvious. Not only is the individual secured, but the hospital can count on a stable income with which to meet a considerable fraction of its operating cost.

There is, however, a segment of our population, estimated at from thirty to thirty-five million people, who are not insurable and whose illnesses will have to be paid for directly by themselves, philanthropy, or governmental agencies at the time the illnesses occur. We believe these agencies should be at the state and local levels rather than on a federal plane. One of our great social problems today is to extend further voluntary prepayment insurance both in its numerical coverage and its quality. We recognize that in terms of days of care provided and completeness of coverage, much remains to be done in the field of insurance. The other aspect of this problem is to work out a sound plan by which that segment of the population of thirty or thirty-five million, incapable of purchasing insurance, can be provided for through proper philanthropic and state or local governmental sources.

The rapid growth in size and complexity of hospitals has resulted in a disturbing conflict between hospitals and those members of their staffs who work in hospitals on a full-time basis. It is necessary that a large hospital be managed by a competent board of trustees acting through an administrator trained in the rather complicated field of hospital management. On the other hand, physicians on the professional staff are responsible for professional services rendered in the hospital to the patient. One of the main points of conflict between hospital administration and the professional staff is in the area where physicians furnish certain specialized professional services in the hospital. It is important that relations between these physicians and hospital management be set up on a basis that will be fair to the hospital, the physician, and the patient whom they serve. Such a relationship should preserve the professional independence of the physician and provide for him an incen-

tive to advance to the highest degree possible in his profession; it should protect the financial interest of the hospital; and it should benefit the patient by stimulating a constant improvement in the quality of service rendered by the department at as reasonable a cost as possible.

Some hospital boards and administrators, not understanding what are the essential components of good medicine, have looked with somewhat greedy eyes on these special departments as a source of revenue to bolster their failing financial situation. These departments should fully reimburse the hospital for all expenses involved, including interest on capital investment, equipment, amortization of the cost of equipment and replacement, and for all other services rendered to the department by the hospital. It is necessary that the physician have control over those factors which have to do with the production of good medical service, such as the kind and quality of equipment and the number and quality of his professional personnel. He should be identified by the patient as the purveyor of the service. The cost of the service should be known to the patient. Much heat and little light is often developed in this area, but with proper understanding of the problem, it can be solved to the benefit of the patient, the doctor and the hospital. Incidentally, the patient is the one who has the primary interest in this matter because all of medicine and all hospital care is designed for one purpose only, to furnish the best possible care to as many patients as within the financial ability of that organization.

MEDICAL EDUCATION

These great advances of medicine in the industrial age, and the demands made upon medicine, have rendered the problem of medical education much more complex. The machinery of medicine involved in medical teaching is intricate and expensive. At the present time, the medical schools are under great financial stress and are in need of large additional funds if they are to carry out their mission properly.

The changes that have taken place in the cost of medical education, due to the industrial development and revolution in medicine, have been enormous. At present it is estimated that it costs the medical school something like $13,000 to educate a medical student during the period of four years. The student on the average pays about $9,000 of that cost.

The American Medical Association has had, since its organization in 1847, as one of its primary objectives the advancement of medical education. In fact, that is why it was organized. Realizing the great need of the people for better medical care, the founders of the AMA knew that to meet this need medical education must be improved and extended, medical research must be fostered and expanded, and new knowledge of diseases must be applied on a constantly broadening scale in the prevention and cure of disease.

Medical education has become extremely expensive, both for the school that produces it and for the individual who receives it. The value of the endowment dollar has fallen. Many schools are in dire need of additional financial resources since, without such resources, they cannot discharge their full duty in this field.

More recently we have been disturbed by the threat of federal influence in the field of medical education. Numerous proposals have been made in the Congress to extend federal aid to meet part of the operating cost of medical schools. Many of us fear that federal control in some degree would follow federal appropriations. Complete freedom of education and research in every field is necessary if we are to preserve the freedom of the individual in our democracy.

The American Medical Association, through its medical education foundation, in association with the National Medical Education Foundation, is attempting to meet the financial needs of the medical schools in different areas of our country. This effort deserves the support, financial and otherwise, of every physician engaged in medicine today.

CHANGING CONCEPTS

There are other changes going on in medicine. Perhaps the saddest one is what has happened to us as individual doctors. We are now among the fallen angels. This is partly our fault, but perhaps more the fault of the times in which we live. People are demanding their medical "pablum" hot off the morning newspaper. The volume of medical service has increased enormously but not enough to meet the demand. We have reinforced our ranks with swarms of technicians. We have divided medicine into departments; specialization and group practice have become the slogan of the moment. The patient no longer has a doctor to care for him, but often a team with a business manager or perhaps a corporation. The cost of medicine has risen and continues to rise. The fact that it has not risen as fast as most other common commodities is not usually recognized. The cost of medical care since 1937-1939 has increased about 64 per cent while the general commodity increase has been around 90 per cent, but that does not impress the person who happens to be ill. In fact, a certain uneasiness pervades the people because of the rising cost of medical care. They fear that they do not have access to some miracle of medicine that is available to others as they learn of the half-baked triumphs of medicine set forth in the maga-

zines and the daily press. If these miracles are not forthcoming, they appeal to their unions and to the Congress. As a result, the breath of socialism or federal medicine is hot on our necks as the mechanics of medicine have become a more and more important part of medicine in the public eye.

This hysteria has invaded the halls of our Congress, and bills concerning almost every phase of medicine clog the calendar. Last year there were more than 400 bills having some medical implication introduced into the Congress of the United States. There are now thirty-two different diseases, such as leukemia, for example, which, if developed within a certain time limit after service in the armed forces, are declared by an act of Congress to be service-connected disabilities. Congress has gone into the practice of medicine to the extent of making determinations of that kind. This service may have been no more than three months in a comfortable chair in Washington or some other bureaucratic center.

Special grants are made by the Congress to set up research projects on various diseases, with the expectation and almost with the demand of solving immediately the cause of these particular afflictions of mankind. The idea exists that discoveries can be hothouse grown, and too little thought is given to the importance of basic research and its relation to the advancement of the science of medicine. I am in no way opposed to the grants for medical research, but I do feel that these grants should be utilized in a somewhat less disorderly fashion. The mechanical age is upon us. People are bemused by the wonders of science, and they are apt to protest if all these marvels are not immediately hawked upon the street.

Into this confused area have moved the social planner, the politician, the visionary, the do-gooder and the plain charlatan. The millennium is just around the corner and all that is needed are more doctors, more nurses, technicians, hospitals, and microscopes. People are being taught that health and health care are fundamental human rights under our present system and that they are being denied this right. Little is said of the individual's responsibility for his health and for that of his family. The most prevalent and perhaps the most significant disease in its ultimate consequence in the chronic illness field is obesity. With the exception of a few cases of glandular disease, this condition is under the control of the individual and requires no technical advice except on the very elementary facts of nutrition.

Medicine is something more than the cold mechanical application of science to human disease. It is also an art—the art of healing. It deals with individuals and not with groups and masses. The emotional winds that buffet the individual and the stress he encounters may be more important than the bacteria or virus that invades the body conditioned for its reception. Sir William Osler observed many years ago that "the way to keep from being sick is to stay well." This implies a direct responsibility on the part of the individual to live rightly and to obey the sanitary and moral code. The mission of a good physician is to teach this to his patients. He must be aware of their problems as individuals and must be able to persuade them to act for their own good.

Today, there is a constantly greater and greater emphasis on the mechanics of medicine—an emphasis on the treatment of the mass rather than of the individual. Good medicine requires an adequate support of basic and specific research, sound medical education, the extension of public health in the preventive field, and constant progress in the practice of the healing art.

At the present time, powerful forces are at work that may affect the environment of medicine for good or evil. These are, to a large extent, the result of the industrial age in which we live. The drive in the direction of socialization of medicine, the rapid expansion of federal medicine, the emphasis on group and cooperative medicine, on comprehensive care under industrial and labor aegis are with us. I mention these not to condemn or defend them at this time, but merely to point out that these influences are at work and we must strive to understand them and consider their effect, not only on the quantity, but on the quality of medicine that may in the future be available to our people.

The expansion of medical cost is stimulated by the present policy of the federal government. On one hand it contributes to a worth-while extension of volunteer hospital assistance through the Hospital Survey and Construction Act, while, on the other, it encourages competition on a federal level with these very hospitals. With the great expansion of federal facilities for the care of veterans with non-service connected conditions and the dependents of service personnel, federal hospital programs are brought into competition with each other and with civilian hospitals. This competition is not only for doctors and scarce technical personnel, but also for patients. This gives another twist to the spiral of ascending medical cost and makes it more difficult for the private and voluntary system to survive. As the cost of health services rises, greater and greater pressure is exerted for more government aid. The programs become larger, they become more impersonal, and the quality of medical care declines.

The responsibility of the federal government for the dependents of service personnel, particularly those

who are drafted into the service, is certainly one that appeals to our consciences and our reason. We believe that the individual is primarily responsible for his own medical care and that of his family. His ability to perform this duty is seriously interfered with by being drafted into the military service. It is reasonable that the federal government should assume some part of this responsibility. It does not necessarily follow that this service should be rendered in federal hospitals. Drafting doctors and employing nurses, technicians, and other scarce personnel to man the expanding federal hospital system depletes the resources of medical care for the entire population. The wisdom of this procedure should be carefully evaluated by physicians and all others interested in the total medical welfare of the country.

Why should we concern ourselves with these things? What can we do and how important is it that we do it? Changing economic, social, and political conditions make certain changes inevitable and often desirable. It is important, however, that changes proceed slowly and that they be guided and controlled in a way that will conserve and extend those basic factors that are essential in any sound system of medical research, teaching, prevention, and practice. Medicine is a moving screen—it does not remain in one position. Changes are taking place, and often they will be irreversible once they have become accepted and entrenched.

The purpose of organized medicine is to study and evaluate the forces that play upon medicine today. The importance of organization in medicine has been stressed by a former President of the American Medical Association, Dr. William Welsh. In 1910, in his inaugural address, he stated, "Organized effort is the distinguishing mark of modern civilization. It is as essential for the advancement of science, of education, of social and industrial reform, of philosophic endeavor, as for the promotion of commerce." The American Medical Association, over a period of many years, has contributed much to the advancement of medical knowledge and its application to the prevention and cure of disease. Medicine has provided a powerful bulwark in the defense of our country. During World War II, our far-flung armies waged successful warfare in tropical areas that previously were almost completely denied access to the white man. Modern medicine cleared the way for the march of our victorious armies.

But I hear that the American Medical Association does not represent the opinion of American medicine. If this be true, it is the fault of American medicine and American doctors, and they should change it—they have the power to change it. The policy of the American Medical Association is set by its House of Delegates, elected by your representatives in your State Association and, in turn, elected from your county society. The American Medical Association is a federation of state associations. It has no punitive or directional power, for you—and the other state and county associations—are the American Medical Association.

CONCLUSION

American medicine is faced with many serious problems. The industrial revolution and the revolution in medicine are facts that face us today. In the political world, the question is how to preserve democracy in an industrial civilization—how to avoid a dictatorship either of wealth or of the proletariat. In the presence of the medical revolution, which is equally a fact, our problem is how to make use of all the facilities of modern scientific medicine and still preserve that fundamental quality of medicine which deals not only with the bodies of men but with their spirits, which we designate as the art of medicine.

If we lose the concept of medicine as an art, we lose the spiritual concept, and medicine is reduced to a mechanical application of the biological, physical, and chemical laws which govern living matter. In this concept, I do not believe. I believe that man is not only a living body but a living spirit and that medicine is not only a science but a healing art and must serve both the body and the spirit of man. With those who believe that there is no spiritual force that orders our destiny, I will not argue—but to you who are here today, I say that the destiny of American medicine is in your hands; that in order to direct this destiny, you must influence the environment in which medicine is practiced. We cannot isolate ourselves but must have a part in directing the great social and economic forces that are moving in the world today and that constantly play upon medicine.

This thought was expressed by Hippocrates nearly 3,000 years ago: "The physician must not only be prepared to do what is right himself but, also, to make the patient, the attendants and the externals cooperate."

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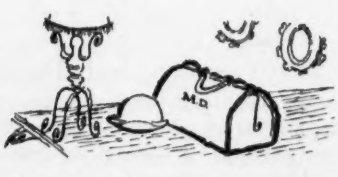
229 West Bute Street.



HOW TO GET ACTION FOR LIBERTY

LEONARD E. READ, Irvington-on-Hudson, New York

I APPRECIATE the privilege of appearing before you and the opportunity of discussing with you how to treat diseases of the body political, rather than the body physical.

You concern yourselves among other things with the physical cancer. I concern myself with the social cancer. This social cancer is presented to us under a great number of labels. It is variously referred to as socialism, communism, fascism, nazism, state interventionism, the welfare state, planned economy, and the new, fair, and various other kinds of deals. Whatever the name under which it appears, it is always a state of governmental ownership and control of the means of production.

Another definition of it would be the communalization of the product of all by force. We did that in the very beginning of our country, in 1620 on the occasion of the landing of the Pilgrim Fathers. It did not make any difference how much or how little any member of the colony produced; it all went into a common warehouse under an authority. And the proceeds of the warehouse were doled out in accordance with the authority's idea of need. In other words, however strange it may sound, the Pilgrims began here a practice of unadulterated communism. Two centuries later, this same idea was held up as an ideal for the Communist Party by Karl Marx: "From each according to his ability; to each according to his need."

Another way of defining this social cancer would be as the direct opposite of Judaeo-Christian charity, which is a voluntary, spontaneous act as distinguished from an act by force.

Or another way of thinking of this sort of thing that confronts us is as political Robinhoodism. Robin Hood always has been and remains popular, and the reason for Robin's popularity is that he robbed the rich to aid the poor. I have never been an admirer of Robin. If the rich came by their properties honestly, Robin was nothing but a brigand and a bandit of the first order. On the other hand, if they came by their properties dishonestly, then Robin was nothing but a show-off, because if he had been intelligently and truly interested in aiding those he purported to help, he would have used his great skills in stopping the robbers in the first place.

I wish to discuss why socialism continues to grow, which it is doing by leaps and bounds. As a matter of fact, socialism has never been more profoundly accepted by the American people than it is today. It is growing, so we should concern ourselves with what we are to do about it and should analyze some of the causes of it. I think you will agree that when you try to get at diseases of the body physical, you try to diagnose them systemically. You try to find the cause and not to deal merely with the manifestations. I will go into some of the causes of this disease of the body political later, but in the beginning I would like to mention a few reasons friends give as to why they personally do not do anything about this problem.

THE IDEA

Many persons think that socialism is historically inevitable, that there is not anything you can do about it, that you must let it run its course, and that you might as well relax and enjoy yourselves. There is another group that makes this excuse for inactivity: They are extremely busy persons, so busy in fact that they have no time to read, study, and meditate upon this problem. There is a third group that believes, "After all, there is nothing I can do about it as an individual."

I should like to comment upon those three excuses, in reverse order. As to the last one, there is nothing at all you can do about it *except* as an individual. As for the person who says that he is so busy with medicine, running his business, or whatnot that he has no time for thinking and studying and reading and meditating upon this subject, he should be more accurate in this expression and say that he gives to this subject a very low priority among all his activities. Actually, there is just as much time to devote to this as one wishes to devote to it. To the person who says that it is historically inevitable and that we might as well let it run its course—well, obviously I don't believe that or I would not be in this work.

I have tried to find instances in history where a country on this type of a toboggan has reversed itself. The search is a bit discouraging. The only

LEONARD E. READ, *President of the Foundation for Economic Education, was one of the special speakers at the 1955 Annual Session of the Texas Medical Association in Fort Worth. This paper was presented at the General Meeting Luncheon, April 27.*

example I ever found that amounted to anything took place in England following the Napoleonic wars. At that time, England was a small country of eight or nine million. Her economy was extremely simple as compared with ours today, but England's debt at that time was greater in relation to her resources than ours is now. Taxation was confiscatory, and the restrictions on the exchange of goods and services were so numerous and great that had it not been for smugglers and lawbreakers, many of the people would have starved.

In short, England was in quite an authoritarian mess. Then something happened, primarily because of the work of two brilliant men, John Bright and Richard Cobden. Those men understood and were capable of explaining the philosophies that earlier had been laid down by such notables as John Stuart Mill, Ricardo, Adam Smith, and John Locke. They went about England preaching and explaining the merits of freedom and freedom of trade. And Parliament was so anxious to find a solution to the trouble England was in that the members listened to these men and began the greatest reform movement in all British history. The reform was largely composed of the repeal of restrictive laws! Queen Victoria, who did not care much about ruling Englishmen in an overriding sense, was the sovereign. Thus these Englishmen roved over the world freely, bringing progress and prosperity which continued until about the beginning of World War I. At that time, this selfsame disease that we are talking about set in again.

It is necessary in analyzing any disease that we isolate the germ if we can and find out precisely what it is. I think we can say exactly what this thing is with which we are dealing. This disease is in the form of a belief. It is a rapidly growing belief in the employment of organized police force—namely, government—as a means to direct the creative activities of citizens within a society.

I could give any number of illustrations, but none is simpler and better known than public housing. I am old enough to remember when, if we wanted a house, we relied upon the free market. We relied first upon the person who wanted a house, which back in my earlier days seemed like a good idea. Next, we relied upon the person who wanted to build the house. Finally, we relied upon the man who wanted to loan the money for the tools and the materials and the labor to build it.

Under that system in America we built more square feet of floor space per person than ever existed in any place on earth at any time in history. Yet in spite of that record, more and more persons are believing today that the only way we can have adequate housing is to use this agency of force—government—to take a part of the livelihood from the people and let the authority determine who needs what. In other words, we are applying the Marxian ideal: "From each according to his ability; to each according to his need" by compulsion.

This belief in the use of force to get things done is on the increase. It follows that as this belief in force increases, there is a corresponding and diminishing faith in free men to get things done. If that reasoning is sound, it then follows that the only solution to this problem must take a positive turn, namely, a restoration of faith in free men.

Of course, I am a radical in this sense. I have much more faith in free men than most persons do. Let me give an example of this loss of faith in free men. If I were to ask most people, "Should the government deliver the mails?" they would say yes—and for a good reason. The government has had a monopoly on that activity for so many decades that everybody else has given up thinking of how they would do it if it were a private enterprise proposition.

I did a little research job and discovered that we deliver more pounds of milk every morning than mail. I next made the discovery that milk is more perishable than a love letter or a catalogue. I also discovered that we deliver milk more promptly, more cheaply, and more efficiently than we do mail. So I said to myself, "Why can't private enterprise deliver mail?" There is no reason at all why it can't—except that we have lost faith in the ability of men to do it.

That is true in all sorts of things. Suppose the federal government had issued an edict 175 years ago that all children from the time they were born until they became adults were to be provided with shoes and stockings by the federal government. Then suppose some radical came along and said he didn't believe that supplying children with shoes should be a government function but should be a family responsibility. I am certain that most people would say, "Would you let the poor go unshod?"

But in this instance, I have an answer. We have not yet made government responsible for our shoes. It is an observed fact that in this country the boys and girls of the poor are better shod than are those in countries where the government assumes that responsibility for them.

My belief in free men, as I have said, is radical—radical in the sense that few people share it. In one simple sentence, I actually believe that you are better able to control your life than I am able to control it for you. That is an extremely radical idea in America today. Sometimes when I am trying to explain this belief to my collectivistic adversaries, I say this to them: "If you will tell me what aspect of

your life you will willingly concede to my control, I can tell you what logically ought to be your idea of the scope of government."

There is only one aspect of their lives that they would willingly concede to my control. They would concede that I have a moral right to defend my life and my property from their aggression because they themselves want that right against me and against others who might aggress against them. If they argue that there are rights superior to the defense of one's own life and livelihood, I ask them to give me the name and address of the person who should have a control over others—other than the defense of his own life and livelihood—and specify what that control should be. They can't do it.

From that kind of reasoning you can derive what should be the function of government. If there is no person who should have a right of control over any other one of us, other than the defense of his own life and livelihood, how can we properly, logically, or justly delegate to any agency, government or otherwise, rights which we ourselves do not possess as individuals?

I insist that any government which indulges in activities other than the equal defense of the life and property of all is hanging on a tenet that is as untenable as the "divine right of kings" theory. If government does not get its right of action from those who form it, from where then do its rights come?

COMMUNICATION OF THE IDEA

It is one thing to have that kind of belief, and it is another thing to get someone else to believe it. How do you do that? There is the crux of our problem. Again I have ideas generally different from most other people. A great number of people want to do something to somebody else. I don't believe in the technique of selling the masses or the man in the street. I believe in another kind of approach.

I will concede that this problem is one in the area of influencing others. But we need to understand the nature of that influence lest we do more damage than good. There are many kinds of influence about which I know nothing, for instance, influencing persons to purchase automobiles and watches and soap and so forth, things that satisfy the desires of the flesh. I am not interested in that on this occasion, but I am interested in influencing persons with reference to the communication of ideas—ideas being accomplishments of the intellect. I believe there is a different technique which should be used in the one than would be used in the other.

There are two ways of communicating ideas, of influencing persons. I have no better terms for them than the rational and the nonrational. I insist that the nonrational devices are of no use on our side—the freedom side—but they are extremely useful to our collectivistic adversaries. They are useful for destructive purposes, for those who would destroy a free society.

An example of a nonrational device is a slogan. The slogan "Kill all the Jews" effectively influenced millions of persons to follow a mad man in Germany. Clever cliches and phrases are other examples of nonrational devices: "What would you do, let them starve?" or "Human rights are above property rights"—things of that sort which have effectively influenced millions of persons to vote for charlatans. My best example of a nonrational device is a man with a messianic voice, one who can stand before a hundred thousand persons and whip them into a maniacal frenzy. That frenzied crowd is extremely influential for destructive purposes. It will kill. But can you imagine the frenzied crowd creating, discovering, inventing? I cannot.

I am suggesting that the job which we want to do is in the creative area. I know of nothing that qualifies as creative more than does the advancement of understanding. The advancement of understanding what? The advancement of the understanding of our philosophy. The greatest single reason that this belief in the use of force is on the increase is that there is nothing substantial standing against it. By this I mean simply that there are few among us, if any, who adequately understand the opposite philosophy to socialism; that is, few of us understand the philosophy of the free market, private property, and limited government. There are very few among us who are skilled expositors of our own philosophy.

You are never going to abolish socialism and the belief in force by beating it out as you would a brush fire. You don't destroy a bad idea except as you replace it with a good one. Unless we know what our own ideas are and can explain them with competency, socialism will continue to grow. The one single antidote there is to socialism is a skilled, competent exposition of our own philosophy. Therefore, it resolves itself into a problem of learning our own philosophy.

I have a couple of observations to make about the learning process. The learning process presupposes two things: (1) a person with a desire to learn a particular subject and (2) a source from which the learning may be drawn. I will concede that we need tens of thousands of persons in America with the desire to learn the free market, private property, limited government philosophy. If they don't have the desire to learn it, they never will learn it. What is it, though, that creates this needed desire to learn?

It is the second part of the equation I have given, the source of learning.

May I illustrate what I mean by referring to nuclear fission. Only a few years ago, there was no widespread desire to learn about nuclear fission, but the moment that one man learned how to release atomic energy—the moment that the knowledge existed in the brain of a man and he communicated it at all—there was automatically created all over the world a desire to learn by tens of thousands of persons who had an aptitude for that subject. It was the source of the knowledge that created the desire. Now we are getting down to the point. How do you develop source? That is a different technique from "selling the masses," from trying to do something to somebody else.

I might tell my golf story to illustrate. I am a member of a golf club having as members 250 dubs, among whom I am a distinguished incompetent. Let us assume for the sake of the argument that my object in this golf analogy is to get all the members to become scratch golfers. So I use the selling-the-masses, working-on-somebody-else technique, and I admonish and exhort my colleagues to become scratch golfers—I, the dub who doesn't know how to be a scratch golfer myself! I am certain that if I persisted in that kind of activity, it would be regarded as repellent, and sooner or later I would be asked to resign from the club.

Now let's reverse the process and let me go to work on the one person on earth over whom I have a control in the creative sense, myself. Assume that I try desperately to become a scratch golfer myself. Now let us make the extremely radical assumption that I succeed. That kind of action on my part would become attractive, and my 249 colleagues would come to me and say in effect: "Leonard, if you can do it, I can do it; but won't you please teach me?" In other words, by my own excellence I would have qualified myself as a teacher.

That is the essence of communication. Qualifying persons as teachers! And how do you do that? You go to work on the one person you can work on, yourself. The teacher is never self-designated. The teacher is always selected by the students. It is the person with the receiving set who does the tuning in, not the broadcaster.

GENERAL CONCERN

I have one more point to make in carrying out our analogy of the two types of cancer. I believe that when the physical cancer is observed, you are just as concerned about it if it hits in one part of the body as in another. Please be as concerned about the social cancer regardless of where it hits the body politic. It is just as dangerous to you if it is hitting at the farmers or at the electric power and light industry rather than at medicine. In the long run, it makes no difference.

One of the nicest admonishments of this principle I have ever read was written by a professor at the University of Chicago by the name of Milton Meyer. His book entitled "These Few" was a discussion of the minority problem, particularly the Jewish minority problem; and he said to his brethren: "If these minority groups would save their own skins and their own souls, they would first fight for the rights of all men, second for others than their own, and last if at all for their own."

There is an excellent thought worthy of consideration by all of us.

Like Father, Like Son

Medicine often tends to be a family tradition, and many physicians today can remember proudly stories told by or about their physician-fathers or have their own recollections of the very early days as a physician. In a dual position is Dr. Paul R. Stalnaker, Houston urologist who has been practicing medicine for more than fifty years. His father, Dr. John William Stalnaker, received his medical degree a century ago.

Shortly after the Civil War in which the elder Dr. Stalnaker served as assistant surgeon in the Confederate Army from Fort Sumter to Appomatox, he moved to Austin and is believed to have been the first city health officer there.

An early member of both the Texas and American Medical Associations, Dr. Stalnaker was a physician with determination, foresight, and initiative in advance of his time. He was the first known doctor of the Southwest to perform successfully an abdominal paracentesis before the days of antisepsis (about 1875). This operation was carried out "against the advice of six other consulting physicians in a case of abdominal ascites" with a red hot trocar and cannula. He also was the first known physician to request and have an autopsy performed on his body.

His autographed copy of the official Confederate book of instruction on surgery and first aid which he assisted in compiling, "A Manual of Military Surgery," published in 1863, was presented to the Texas Medical Association Memorial Library on the Association's centennial anniversary in 1953.

Postgraduate Courses Offered

A postgraduate course in bedside cardiology will be offered by the University of Texas Postgraduate School of Medicine in Houston on August 17, 24, and 31. Another course, in obstetrics and gynecology, will be offered August 25. Full information may be obtained by writing the Postgraduate School of Medicine, Texas Medical Center, Houston.

FLUORIDES IN EVERYDAY LIFE

NICHOLAS C. LEONE, M. D., Bethesda, Maryland

THIS is a brief review of the highlights in the development of our knowledge about fluorides, dealing first with fluorine as an element and then going to the forms in which it is encountered daily.

Our earliest scientific knowledge of the fluorine compounds dates back to 1670, when the Nuremberg artist Schwanhard attempted to etch glass by means of vapors generated from fluorspar (CaF_2—48.67% F) treated with sulfuric acid.[11] In 1771 Scheele first obtained an aqueous solution of hydrogen fluoride by the decomposition of fluorspar.

DR. NICHOLAS C. LEONE, *Chief, Medical Investigations, National Institute of Dental Research, National Institutes of Health, Public Health Service,* *was one of the special speakers for the 1955 Annual Session of the Texas Medical Association. This paper was read at a general meeting April 27.*

Morchini next attracted attention to fluorides in living organisms in 1803 when he observed the release of hydrofluoric acid vapor from fossilized elephant teeth treated with sulfuric acid.[26, 27] Morchini noted that the older and better preserved fossilized specimens possessed a higher fluoride content. Later, Berzelius and Gay-Lussac, in 1807, substantiated these claims and went on to demonstrate the normal presence of fluorides in human and animal bones. About 1846, George Watson, a Scotch chemist, showed fluorine to be widespread in nature by demonstrating its presence in fresh and salt water, vegetable ash, blood, and milk. Moissan isolated the element by electrolysis in 1886.[23]

There is little doubt that nature has imposed daily contact with fluoride upon us, for 0.1 per cent of the earth's crust is composed of this element in different forms. There are a few scattered areas in the world where it is found in high concentration in the form of cryolite (Na_3AlF_6—54.30% F) or fluorspar (CaF_2—48.67% F). These areas are mainly in Greenland, India, and a few scattered locations in Africa and China.[5] There are extensive fluorspar deposits in Illinois and Kentucky where fluorspar mines have been worked for more than 100 years. In some regions of Texas fluoride is found in the ground water, in higher than the usual levels, but there are no important fluoride soil deposits.

Nearly all foods and many waters used for domestic purposes contain fluorides. In addition, man has increased its presence in his environment through developments in agriculture and industry and, more recently, in medicine.

Fluoride compounds are extensively used in industry, particularly in the manufacture of aluminum, steel, and heavy metals. Fluorine is a constituent of many refrigerants, fire extinguishing agents, insecticides, rodent poisons, fertilizers, and some commercial large-animal feed supplements. Fluorine is freely distilled into the air by some oil and metal industries, gold and silver smelters, chemical industries, brick and cement works. The most direct possible contact with fluorides is through the mining of cryolite and the subsequent commercial handling of cryolite and rock phosphate. The number of people exposed to this contact is relatively limited.

Medical interest in industrial atmospheric pollution has increased. The actual fluoride content of such an atmosphere varies considerably, but air-borne contamination of farm lands adjacent to aluminum, steel, and heavy chemical plants has resulted in damage to local crops and animals. Air pollution is of immediate concern to the sanitarian and the industrial hygienist, and the physician is also alert to the possible implications to clinical medicine.

This is but a partial list of contacts with fluorides in daily life.

FLUORIDES IN WATER SUPPLIES

Our earliest information on the human dental effects of fluorides stems from a 1901 report by Eager, a Public Health Service physician who examined Italian emigrants in Naples. Quoting Eager's report to the Surgeon General, "one is struck by the frequency of a dental peculiarity common among the inhabitants of the Italian littoral and known as Denti di Chiaie or Chiaie teeth. This defect was first described by Professor Stefano Chiaie, a celebrated Neopolitan, and bears his name."[10]

The astute observations of McKay and Black, begun in Colorado Springs about 1908 and published in 1916, associated dental mottling with domestic water supplies. McKay, a practicing dentist with an alert, open mind, had epidemiologic direction in thinking.[22] His work gave impetus to Dean and others, who, using epidemiologic techniques, proved beyond a doubt that fluoride in drinking water produced dental effects under specific circumstances.

These early investigators found that when drinking

water contained concentrations substantially greater than 2.0 parts per million of fluoride, there often developed unsightly, brown-stained, hypocalcified or hypoplastic teeth. They also noted that there was a relationship between the amount of fluoride in the drinking water and dental caries; it was found, for example, that 1.0 parts per million of fluorides in drinking water used during the tooth formative stage of life (0 to 8 years) was beneficial. The work of Dean, in particular, established the anti–dental caries effect of fluorides on a sound epidemiologic basis.[6] As early as 1892 Crichton-Browne had suggested that the high incidence of dental caries in England was due, at least in part, to a deficiency of fluoride in the diet.[4]

One part per million of fluoride in drinking water is now generally accepted by the dental and medical professions as desirable in temperate climates, and the general public is gradually and surely becoming aware of the beneficial dental effect of this element at this concentration.

The first mechanical addition of fluoride to a public water supply was in Grand Rapids, Mich., in January, 1945.[7] As of November 18, 1955, there were 1,066 communities with a total population of 20.45 million persons in the United States receiving added fluorides in their drinking water. Some communities graduate the amount of mechanically added fluoride on a seasonal basis to provide a consistent fluoride intake.[32] There are also more than a thousand communities that have been using local water supplies containing natural fluorides varying from a trace to 16.0 parts per million for many years. Many of these water supplies have fluoride concentrations approximating that advocated for dental caries prevention (1.0 parts per million).

It is of further interest that as of January, 1955, fluoridation has been a ballot issue in 194 United States communities. It was defeated in 108 and approved in 86.[13]

Figure 1 shows the known natural high fluoride areas in the United States.

The problems arising from the use of fluoride compounds by industry unfortunately have been used to oppose the judicious use of trace amounts of fluoride in domestic water supplies. Actually, these are two entirely different problems. The work of Roholm and others, prior to 1937, concerned with the physiologic effect of fluorides on cryolite miners constantly exposed to dust containing very high concentrations of fluoride, is repeatedly quoted, with interpretation of such work confusing recent issues in regard to the value and use of low concentrations of

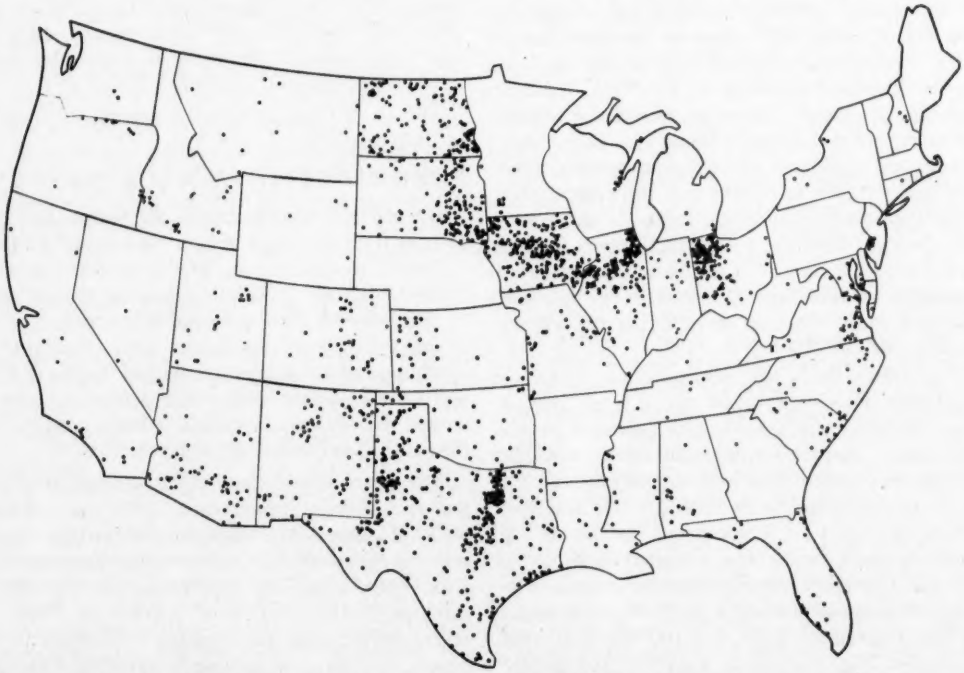


FIG. 1. Towns in the United States using naturally fluoridated water. The dots represent towns in which naturally occurring fluorides in the ground water exceed 0.7 parts per million. (From Testimony of the Public Health Service, Department of Health, Education, and Welfare, before the House Committee on Interstate and Foreign Commerce, in Connection with Hearings on H. R. 2341, May 25-27, 1954.)

fluorides in domestic water supplies.[16] When Roholm first described bone changes due to fluorides, they were gross changes, and without question, unusual. Since his early descriptions (1937), similar bone changes ascribed to fluoride effects have been reported by a number of investigators under various circumstances.[1, 24, 28, 30] In most instances, the number of cases was limited, and attention was directed to individuals with evidence of gross radiographic bone change without reporting the absence of such change in other members of the same population group or considering other possible causes.

The introduction of trace amounts of fluoride into water supplies as a dental public health measure has created a new interest in the problem. The unusual bone changes reported by Roholm in cryolite workers, by implication, have been cited as typical of the bone changes following fluoride exposure from any source and in any amount. These implications have created a bias in the interpretation of the physiologic effects of fluorides such as encountered in water fluoridation, and this bias has pervaded the evaluation of data concerning domestic water supplies containing but trace amounts of natural or mechanically added fluoride.

FACTS ABOUT FLUORIDES

With this brief running account as a background, we can now discuss some of the generally known facts about fluorides. Part of these facts have been derived from careful studies of humans and of small and large animals. Part stem from a recently completed ten-year epidemiologic study of two Texas communities, Bartlett and Cameron.[16] The ten-year study, initiated in 1943, included 237 people, half of whom used a local water supply containing 8.0 parts per million of fluoride for an average of 38 years. The remainder of the group resided for the same length of time in Cameron, the control town, with a water supply containing 0.4 parts per million of fluoride. This study afforded an opportunity to evaluate a group of human beings using a water supply containing approximately eight times as much fluoride as that advocated for the prevention of dental caries, to determine if there were any detectable clinical, laboratory, or radiographic effects of significance through long exposure.

The statements which follow are presented as though in response to posed questions and, as indicated, derive from several sources, including the long-range human epidemiologic study mentioned.

1. Under what circumstances can beneficial dental effects of fluorides be demonstrated in humans?

a. It is assumed that exposure to fluorides must occur during the tooth formative period (0 to 8 years of age) if the maximal dental effects are to be demonstrated.[8] Under these circumstances the total number of decayed, missing, and filled permanent teeth may be reduced by as much as 65 per cent among children up to 14 years of age. Continued use of a fluoride water will produce dental benefits which persist in adult life.[31]

b. Consuming water with more than 1.0 but less than 2.0 parts per million of fluorine may produce minimal dental mottling, ordinarily difficult to detect, but still preferable to insufficient fluoride in the water. This degree of mottling usually appears on the points of the cusps or on incisor edges. The most frequently affected teeth are the bicuspids and the least affected, the lower incisors.[9]

c. The topical application of a 2 per cent sodium fluoride solution to the teeth of children has been shown to be beneficial, but the benefits to adults are questionable.[2, 15]

2. What information is available on the toxicology and pharmacology of fluorides in man and animals?

a. Information on toxic doses in man is limited, being derived from accidental poisonings and suicides. Because nausea and vomiting are early symptoms, it is difficult to determine the minimum oral dose that is lethal to man. It appears that a retained oral dose of 4.0 to 5.0 Gm. of sodium fluoride will produce death. Both death and recovery have been reported from 0.5 Gm. As much as 0.25 Gm. has been taken orally by humans, and except for nausea without vomiting, no serious effects resulted.[3, 18, 25]

b. The fluoride intake from water containing 1.0 part per million of fluoride (1 mg. per liter) is less than 0.1 mg. per kilogram of body weight.

c. In a study in dogs, soon to be published, it was found that 36 mg. of fluoride per kilogram of body weight, given by intravenous infusion, uniformly caused death. Twenty-five mg. per kilogram of body weight will produce death in 8 to 36 hours. With 15 mg. per kilogram of body weight there was survival without ill effect. The dosage of sodium fluoride was computed in terms of fluoride ion.[25]

d. For mice, the oral medial lethal dose of sodium fluoride, calculated as the fluoride ion, is 46 mg. per kilogram of body weight and the intravenous medial lethal dose is 23 mg. per kilogram. This is in close agreement with the toxic dose for dogs.[25]

e. There is firm evidence that prolonged contamination of pasture land by high concentrations of airborne fluorides from nearby industries produces detectable effects in cattle. However, these levels must approximate or exceed 2.5 mg. per kilogram of body weight for long periods and the effects are due to ingestion of contaminated forage.[12]

f. In cattle, daily consumption of 2.5 mg. per kilogram of body weight for at least six months is required to produce detectable fluoride effects. The principal findings are mottling of the teeth (if the teeth are calcifying during the period of exposure), bony exostoses, and radiographic evidence of increased bone density and coarsened trabeculation. This dose does not affect reproduction or milk volume.[12]

g. The fluoride content of cows' milk does not exceed 0.2 to 0.5 parts per million of fluorine even when toxic doses are administered over long periods.[19, 33]

3. What are the main routes of excretion of fluorides?

a. In man and animals the principal route of excretion is by way of the urine and feces. Some fluoride is excreted through the skin, but quantitative determinations are difficult and our information on this route is not as complete as might be desired.[20]

4. Is there transplacental passage of fluorides?

a. Transplacental passage of fluorides has been demonstrated in animals by comparative analysis of maternal and fetal tissues.[12, 34]

5. What are the physiologic effects on man of prolonged ingestion of water containing a high level of naturally occurring fluorides?

a. The bizarre bone changes described in earlier studies on fluoride effects among cryolite workers do not occur in population groups using water supplies containing natural fluorides ranging from 3.0 to 8.0 parts per million.[17, 21]

b. A small percentage of those persons exposed to 8.0 parts per million of natural fluoride in drinking water for long periods showed radiographic evidence of increased bone density and coarsened trabeculation, but no physical or functional effects were associated with these changes. There were no significant differences in the number or types of bone fractures between the study group (8 parts per million) and the control group (0.4 parts per million).[17]

c. Analysis of tissues from a human autopsy showed approximately six times the normal fluoride content of bones after long exposure to high fluoride levels in water. There were no remarkable histologic soft tissue changes. Radiographs showed minimal increased bone density and coarsened trabeculation, but these conditions were not associated with impaired health or bodily function.[16]

d. There is some evidence that the increased bone density occurring in persons exposed to high levels of fluorides may be beneficial to adults.[16]

e. From the studies recently completed, it can be stated that "no clinically significant physiological or functional effects resulted from prolonged ingestion of water containing excessive fluorides, except for dental fluorosis."[17]

REFERENCES

A bibliography may be obtained from the author.

SIMPLICITY OF THE OFFICE BIOPSY

R. R. BRAUND, M. D., Memphis, Tennessee

BIOPSY is defined as removal and examination (usually microscopic) of a piece of tissue from the living body, especially for diagnosis. Its importance in establishing the diagnosis of cancer generally is accepted. To show that this important procedure can be performed in most instances in the physician's office or clinic is the purpose of this paper.

The location, extent, and general feature of a lesion may be established by clinical examination, but microscopic examination is necessary for a positive diagnosis. Several methods of obtaining tissue for microscopic study have been developed and all have merit. The pathologist usually requests that the material to be examined be obtained from the margin of the tumor and that it include a piece of normal tissue, preferably removed by cutting with a knife. Electric cautery has been advocated by some surgeons because it seals the blood and lymph vessels. The pathologist contends it burns or cooks the specimen often beyond recognition. Aspiration biopsy by means of a needle is objectionable to some pathologists because of the small amount of tissue obtained. The use of a biting forceps is frowned upon by others because it is said to crush the tissue.

An objection to the use of the cold knife method of tissue removal is that it makes the procedure too complicated for routine office use and too expensive if hospitalization is necessary. The simpler and less expensive the procedure is made, the more frequent it will be performed. The biopsy of deep seated

From the Division of Surgery, University of Tennessee School of Medicine and the West Tennessee Cancer Clinic.

Read before the Texas Academy of General Practice, Galveston, September 10, 1954.

lesions such as in the stomach and liver and of all breast tumors requires hospitalization and operating room technique, but the vast majority of biopsies can be performed in the office or clinic.

During the past six years we have performed in the University of Tennessee Cancer Clinic and our office 6,170 biopsies or local excisions. They have been performed by attending physicians, residents, interns, and medical students. Great emphasis is made on the importance of the biopsy in student instruction. The student who does a biopsy in the clinic will be more likely to do one in his office. That they have been performed with comparative safety and with reasonably accurate results is evidence that they are being satisfactorily done.

The greatest number of biopsies and excisions were of skin lesions, as one would expect considering the high incidence of skin cancer in the southern states (table 1.) When the lesion was small, complete excision with a cold knife was performed, care being taken to have an adequate margin of normal tissue around the lesion in all directions. This required either local or regional anesthesia and suturing of the skin. In larger lesions and in smaller ones in which roentgen-ray therapy would be the preferable method

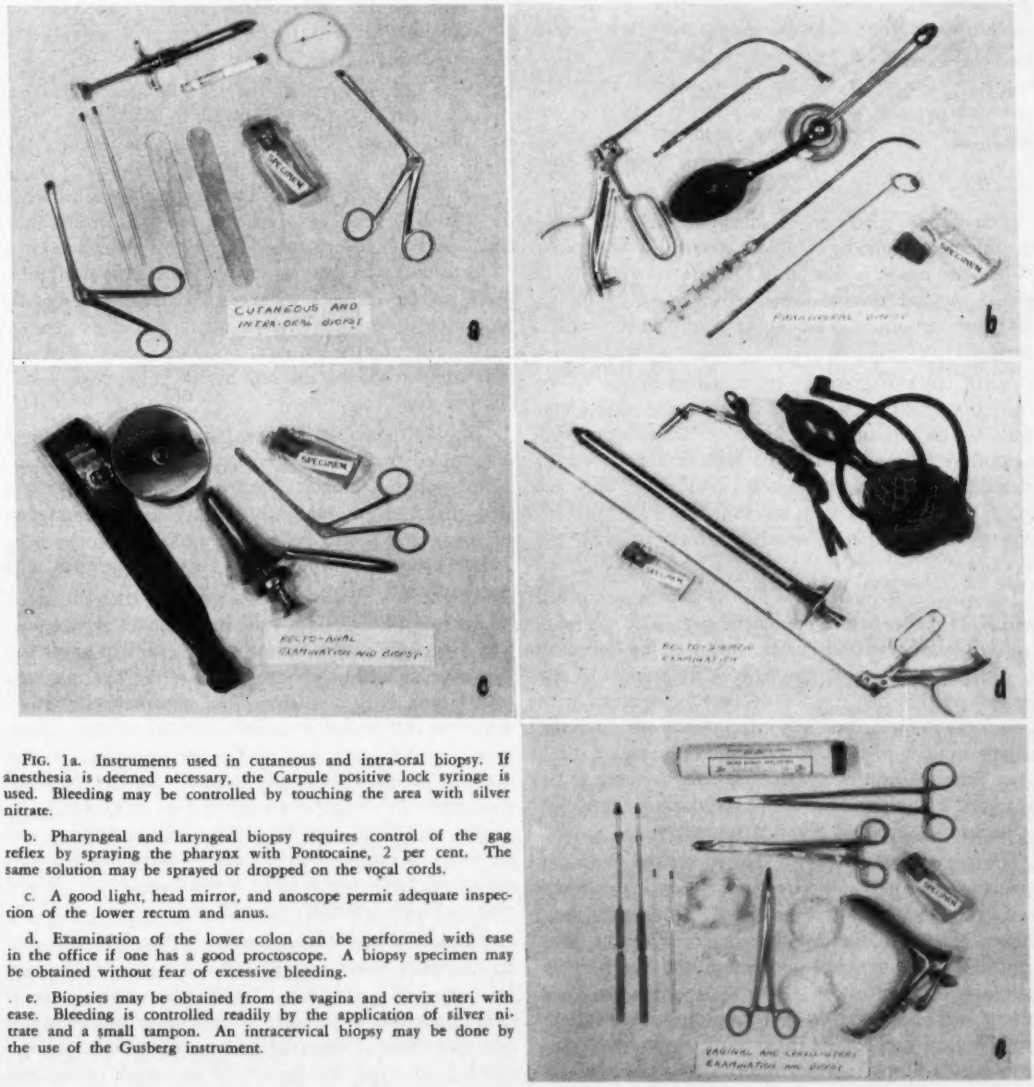


FIG. 1a. Instruments used in cutaneous and intra-oral biopsy. If anesthesia is deemed necessary, the Carpule positive lock syringe is used. Bleeding may be controlled by touching the area with silver nitrate.

b. Pharyngeal and laryngeal biopsy requires control of the gag reflex by spraying the pharynx with Pontocaine, 2 per cent. The same solution may be sprayed or dropped on the vocal cords.

c. A good light, head mirror, and anoscope permit adequate inspection of the lower rectum and anus.

d. Examination of the lower colon can be performed with ease in the office if one has a good proctoscope. A biopsy specimen may be obtained without fear of excessive bleeding.

e. Biopsies may be obtained from the vagina and cervix uteri with ease. Bleeding is controlled readily by the application of silver nitrate and a small tampon. An intracervical biopsy may be done by the use of the Gusberg instrument.

of treatment, we employed the biting biopsy forceps either with or without anesthesia.

Anesthesia is used for two purposes, to prevent pain and in cases of pharyngeal and upper gastrointestinal and respiratory tract lesions to abolish or reduce the gag reflex. Since cancerous tissue has little or no nerve supply, there is no pain in obtaining a biopsy from the tumor itself. Should one wish to obtain a section of normal tissue at the margin of the lesion, a sharp biting forceps causes no more pain than does the injection of procaine. The entire procedure requires only a fraction of a second.

TABLE 1.—*Anatomic Source of Biopsy Specimen.*

Skin	4,265
Mouth, pharynx, larynx, esophagus	673
Paranasal sinuses	7
Subcutaneous tumors—	
Surgical	107
Aspiration	59
Cervix uteri	721
Vulva vagina	54
Rectosigmoid	284
Total	6,170

The biopsy specimen of subcutaneous tumors frequently is obtained by complete removal of the tumor. When the lesion is too large for safe removal in the office, the specimen is obtained by exposing the tumor and obtaining a wedge of tumor tissue with a knife.

Sufficient material may be obtained by use of the aspiration method without incising the skin. One must be certain his pathologist is sympathetic with aspiration biopsy or he will receive many reports marked "insufficient material for diagnosis." We have found this sympathy is in more or less direct proportion to the familiarity of the pathologist with the procedure.

Intra-oral and pharyngeal lesions can be examined readily in the office by pinch biopsy. The use of a knife is almost certain to be followed by bleeding to such an extent that suturing is necessary. If one desires, the mucous membrane may be sprayed with 2 per cent Pontocaine. Not infrequently we have the patient hold a pledget of cotton, moistened with a 2 per cent solution of cocaine, against the area to be examined by biopsy. The slight bleeding is controlled by pressure. Suturing is rarely necessary.

The great emphasis being placed on the early detection of uterine cancer by vaginal smear examination has made many women more cancer conscious. Cancer of the cervix is being detected in the subclinical stage. On gross inspection the cervix may appear normal or show slight cystic changes. The patient may deny any of the symptoms we associate with cervical cancer. In these early suspicious cases we obtain a biopsy specimen from four areas about the cervical os—at 12, 3, 6, and 9 o'clock. Occasionally material is obtained at the same time from the endocervix by using the Gusberg biopsy curette. In only 4 patients have we found it advisable to do a cold knife conization of the cervix to obtain additional material. All were clinically thought to have cancer; 2 of the 4 proved positive. One had had 5 negative biopsies prior to her conization. A later review of the 5 "negative" biopsies showed 3 to be positive.

Bleeding after biopsy of the cervix is seldom troublesome. We routinely place a tampon against the cervix, at the same time instructing the patient to remove it the following day. Bleeding was alarming in only 3 of the 721 patients who had cervical biopsies in the office. They were hospitalized and the vagina packed. In each there was an ulcerated lesion involving the vaginal mucosa.

It is not uncommon for some physicians to hospitalize patients for a cervical biopsy. Since many families carry some form of hospitalization, they may request that it be done in a hospital. Let us examine the cost record. Two days' hospitalization at $10 to $15 per day, operating room $15, anesthesia $15, and laboratory fees $10 to $15 gives a total of $70 to $80 plus the physician's fee to obtain a biopsy of a cervix. In the physician's office the pathologist's fee plus the office visit probably would not exceed $20. The greater the cost, both in time and money, the smaller will be the number of patients to have a biopsy done.

Not infrequently we see patients who have been cauterized for chronic cervicitis in some physician's office without biopsy only to find months later that they had cancer. Make the biopsy simple and make it cheap and it will be done. A cervical biopsy is an office procedure which physicians can perform with accuracy and safety.

The use of the endoscopic instruments may require some experience to become perfect. Every physician, however, should be able to visualize the hypopharynx and larynx with a mirror. We suggest trying it on the next 10 patients complaining of a sore throat and it will be easy to visualize the pyriform sinuses and the larynx. When the normal becomes familiar, the abnormal will be recognized at a glance. The physician should bear in mind that the patient past 40 years of age who has an unexplained lump in his neck will have cancer nine times out of ten. If the doctor looks carefully, he will find it.

The use of the anoscope and proctoscope is simple and accurate providing the colon is properly cleansed by castor oil or enemas. Unless the colon is clean, it is impossible to perform a satisfactory examination. No anesthesia is required except in children. Specimens from rectal lesions within the reach of the ex-

amining finger usually can be obtained through the anoscope. Hemorrhage is seldom bothersome. We have had only 1 instance of severe bleeding following a rectal biopsy.

EQUIPMENT

Let us look for a moment at some of the equipment needed to obtain adequate biopsy material in the office (fig. 1). Perhaps some doctors have better instruments than these. With this equipment we have performed more than 6,000 biopsies and it is still being used. The cost to date is less than 4 cents per biopsy. For the physician doing general practice excellent biopsy instruments may be obtained for less than $100. Their use will improve diagnostic accuracy and increase the confidence of the patient.

Having obtained the biopsy material, the physician should place it without delay in a small bottle of 10 per cent formalin with the patient's name on the bottle. This material together with a brief history and the clinical findings and diagnosis is then ready to go to the pathologist. It is important that he know the patient's age, sex, and race. Pertinent clinical information as to the location, size, presence or absence of ulceration, and previous treatment of the lesion should be furnished. When mailed, the specimen bottle should be packed in a small carton to prevent breakage.

SUMMARY

A brief review of our experience in more than 6,000 office and clinic biopsies has been presented. We have found that the simpler the procedure for obtaining the specimen, the more likelihood of its being performed. It is not necessary to use Novocain or a scalpel and make a minor surgical procedure out of a biopsy. Adequate material in almost all cases can be obtained without the benefit of anesthesia. Intra-oral and pharyngeal lesions as well as lesions of the cervix uteri are associated with little bleeding if obtained in this manner. With proper equipment and care a biopsy can be performed in the most remote physician's office with as much safety as in our large teaching hospitals.

1118 Madison Avenue.

USE OF NISENTIL HYDROCHLORIDE IN UROLOGY

ALVIN J. ASHMORE, M. D., F.I.C.S., and O. B. MOON, M. D., Corpus Christi, Texas

THE synthesis of Nisentil (formerly known as NU 1196) was announced by Ziering and Lee in 1947.[16] These workers found the compound to consist chemically of 1,3-dimethyl-4-phenyl-4-propionoxypiperidine; it presented the form of colorless crystals, with a melting point of 212 to 214 C. The analgesic activity in rats, determined by a modification of method of Ercoli and Lewis,[1] proved to be 0.97 that of morphine when injected subcutaneously, but 1.4 that of Amidon when given orally. Preliminary studies on analgesic activity also were made by Holland and Gross.[4] In man, Nisentil showed somewhat less analgesic activity than morphine, with a shorter duration of analgesia. Doses up to 15 mg. produced mild sedation, with only such mild side effects as slight dizziness, minor itching, and minimal nausea. There was no significant alterations in blood pressure or pulse rate. Results of extended studies by the same group[2] demonstrated that the peak analgesic effect of Nisentil, given subcutaneously, occurs sooner than with morphine. Furthermore, no difference in peak height was observed whether the administration of Nisentil was oral or subcutaneous, indicating good absorption from the gastrointestinal tract. After intravenous injection, the peak was higher and the degree of analgesia shorter. The side effects of Nisentil were minimal relative to morphine.

An early report on the clinical use of Nisentil in patients with pain is that by Houde, Rassmussen, and LaDue.[5] In those patients in whom Nisentil gave effective relief of pain, the average duration of relief was one and a half hours after oral administration and two and a half hours when given subcutaneously.

EARLY USE IN OBSTETRICS

The relatively high potency of Nisentil and particularly its short duration of action led to its trial in obstetric patients during labor, and the majority of the early reports on therapeutic use were devoted to this field. October, 1949, witnessed the appearance in print of articles by two distinct clinical groups. The series of Smith and Nagyfy[12] comprised 186 obstetric patients, all of whom received subcutaneous doses of 30 mg. or less. The analgesia was greater than that from morphine in doses of 1/6 and 1/8 grain. A slightly higher dose was prescribed by Hapke and Barnes,[3] who noted the effects from subcutaneous injections of 40 mg. in 500 patients during labor. Adequate pain relief was achieved in 90 per cent of those tested, and no untoward side reactions were manifest. The progress of labor was

not significantly delayed. In 311 cases, a special attempt was made to determine the effect of Nisentil upon fetal respiration, with measurements of the time between delivery and (a) the first respiration and (b) the first lusty cry. There was no significant depressant effect from Nisentil if given at least two hours prior to delivery and little depressant effect generally, except in a subgroup of 30 patients who received disproportionately large amounts, that is, five consecutive 40 mg. doses at regular two hour intervals.

A total of 1,000 obstetric patients comprised the case material for the study by LaForge.[8] The routine use of 40 mg. of Nisentil subcutaneously gave good analgesic effects in 50 per cent of the mothers. Subsequent experience showed much better results, that is, "marked to full analgesia" from 87 per cent of the doses, when a base-line dose of 60 mg. was adopted with variations from 40 mg. to 80 mg., depending upon the weight of the patient. Averagely, five minutes was required for the onset of analgesic action; the mean duration was one and a half to two hours. The identical number of cases was reported on by Kane.[7] One a similar regimen of treatment—that is, 40 or 60 mg. of Nisentil subcutaneously repeated when necessary at two to eight hour intervals—satisfactory analgesia was obtained in 98.1 per cent of cases. Analgesia classified as "full or marked" occurred in 80 per cent with repeated doses. Concurrent medication with scopolamine appeared to prolong the duration of the maximal effect for about one hour.

USE IN UROLOGY

The rapid onset and relatively brief duration of effect from Nisentil, as set down in these obstetric reports, suggested to McCrea and Post[10] the possible utilization of this comparatively new analgesia in urologic procedures. After preliminary trial establishing 30 mg. as the optimal intravenous dose, the authors employed Nisentil in 100 patients requiring cystoscopic examination. In 5 of these, the procedure had to be postponed because of side effects. Of the balance of 95, the analgesia was "marked" in 40, "moderate" in 34, "little" in 11, and "none" in 10. The duration of analgesia averaged 16 minutes, with a range of from 2 to 60 minutes. Except for a convulsive seizure in 1 patient, the side effects as seen in the other 4 were not serious, consisting chiefly of dizziness (4 patients) and vomiting (1 patient). It was considered an advantage that no sedative effect occurred in 48 per cent of the patients; when this did appear, it persisted generally for not more than 30 minutes.

We, likewise, were attracted by the prospect of achieving more satisfactory analgesia for urologic procedures. This was especially true with respect to cystoscopy, which has continued to be associated with fear and apprehension despite the trial and abandonment over the years of a succession of agents. Furthermore, we sought rather specifically for a method suitable for office procedure rather than for the hospital where, of course, Pentothal Sodium, nerve block, and the anesthetic gases are available. Defined more precisely, we looked for an agent we could give the patient upon arrival at the office which would allay his apprehension, lower his pain threshold, last not longer than two hours, and yet permit his complete cooperation. Morphine, obviously, did not fulfill these criteria.

Accordingly, in November, 1952, we began using Nisentil (1,3-dimethyl -4-phenyl-4-propionoxypiperidine) intravenously. A dose of 30 mg. almost always produced immediate euphoria, which often caused the patient to say that he was "getting drunk." Of the initial 25 cases, 7 complained of nausea, lasting about five minutes. Once this feeling had passed off, the patients were generally relaxed, calm, and cooperative. They also were able in most instances to get off the table and leave the office at the conclusion of the procedure, although a period of at least 30 minutes in the supine position is recommended to obviate the recurrence of nausea and to prevent dizziness; transfer of the patient to a cot or couch for the "rest" period is probably the most practical expedient. We also found nausea and vomiting to be minimized by the administration, intramuscularly, of 50 mg. of Dramamine 20 to 30 minutes before the Nisentil. Since we have begun this, we have had only about 1 per cent of the patients complain of nausea, and none has vomited. Residual discomfort, that is, after the analgesic action of Nisentil had worn off, in our experience was controlled in most instances by ½ grain of codeine.

To date, Nisentil has been used, in doses of 30 mg. intravenously, in more than 600 office procedures. In this series of 600 there was only 1 reaction. This response, urticarial in nature, was relieved by an intravenous injection of 2 cc. of Benadryl. The patients ranged in age from 16 to 101, with an average of 38 years. Table 1 shows the procedures used, with the number of patients for each.

TABLE 1.—*Urologic Procedures in Which Nisentil Hydrochloride Was Used in 624 Patients.*

Procedure	No. Patients
Cystoscopy-dilatation of ureteral stricture	252
Diagnostic ureteropyelograms	130
Ureteral manipulations (stones and the like)	35
Bladder biopsies	24
*Prostatic biopsies (needle)	9
Cystourethroscopic examination	73
*Ligations of vas deferens	79
*Circumcisions	22
Total	624

*In conjunction with procaine infiltration.

We found that, whether the patient was a 16 year old girl or 101 year old man, 30 mg. of Nisentil (intravenously) given 20 to 30 minutes after 50 mg. of Dramamine (intramuscularly) gave us immediate analgesia. It also gave us a cooperative patient who had lost his fear and apprehension of having a cystoscopic or other urologic procedure. The effects of the Nisentil would last the length of the procedure, and the patient could get off the table although a 30 minute rest in the supine position is advisable. There seems to be no contraindication except the person with a definite urticaria would not be given Nisentil again.

SUMMARY

The historical development of Nisentil has been reviewed. Nisentil Hydrochloride has been used in more than 600 urologic procedures. It has the advantage of being quick acting and practically free of side reactions. It leaves the patient with the use of all of his faculties and completely free of fear and apprehension. It is the agent of choice to give prompt attainment of maximal analgesia. Dramamine, 50 mg., is used routinely to prevent nausea, and the patient should remain in the supine position for at least 30 minutes after the drug is given. There seems to be no contraindication as to age. We have observed no appreciable change in blood pressure.

ADDENDUM

To date we have used Nisentil Hydrochloride in more than 1,000 patients, and our results are the same.

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EIGHTH WORLD HEALTH ASSEMBLY

The eighth World Health Assembly, the first to be held in the Western Hemisphere, convened in Mexico City May 10-31. Included in the plans for international health for 1956 are the eradication of malaria, the public health aspects connected with the use of atomic energy, and the expansion of the World Health Organization's international poliomyelitis program. Dr. Ignacio Morones Prieto, secretary of health and welfare of Mexico, was elected by acclamation as the new president. Dr. H. van Zile of the United States Public Health Service is a member of the organization's executive board.

CASE REPORTS

THALLIUM POISONING OF CHILDREN IN TEXAS

Report of 3 Cases

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THE alarming increase in cases of thallium poisoning of infants and children in Texas is cause for great concern. Insecticides and rodenticides containing thallium are appearing in large quantities on our markets. Most of these are in forms palatable to children, either as small nut-shaped pellets or as sweet syrups or solutions to be spread on bread and cookies which careless parents leave within reach of their offsprings. Thallotoxicosis is becoming a serious problem, but fatality usually can be prevented if the physician is familiar with the symptoms and the necessity for rapid treatment. We will discuss the symptoms and treatment of thallium poisoning and present briefly 3 recent cases we have treated.

Thallium is a bluish-white, fusible, heavy metal which resembles lead in its reactions. This metal was discovered in 1861 by Lamy, who suspected it was toxic as he suffered from general lassitude and weakness of extremities while working with it. In 1898, it was first used to treat night sweats in tuberculosis with the side effect of rapid depilation. Saberaud used thallium in 1900 as a depilatory in ringworm, but its use was abandoned because of the toxicity.

The lethal dose of thallium is unknown. However, it has been reported that 2.5 Gm. killed an adult, 1.7 Gm. killed 3 boys, and 8 to 10 mg. of thallium acetate per kilogram of body weight was fatal to several children.

There have been sporadic outbreaks of thallotoxicosis in the United States, the most famous being in California in 1932. One hundred pounds of thalgrain (thallium-coated barley) was obtained illegally and made into tortillas. Thirty-one persons ate the tortillas, and 22 of them developed symptoms of thallium poisoning, with alopecia and pains in the legs and feet being the chief complaints. Of the 22 patients, 14 were hospitalized, 6 died from acute thallotoxicosis, and 2 died two months later.

It is believed that thallium acts on the autonomic nervous system. The hair of the scalp alone is under the trophic influence of the internal secreting glands through the sympathetic nervous system. In thallium poisoning, the hair of the rest of the body, including the internal two-thirds of the eyebrows and a fringe at the edge of the forehead, remains intact.

There is a definite selective action on all forms of nervous tissue. Microscopic examination reveals degeneration of peripheral nerves, axons, myelin sheaths, basal ganglia, and cerebellum and chromatolysis of neurons. There are degenerative changes in the myocardium, granular and fatty infiltration of the liver, degeneration of glomeruli and convoluted tubules of the kidneys as well as optic nerve degeneration.

SYMPTOMS AND SIGNS

The symptoms and signs are divided into the subacute or chronic and the acute poisoning.

In subacute cases, the only characteristic sign is alopecia. Many other complaints have been reported in these patients, such as fatigue, emaciation, stomatitis, anorexia, vomiting, diarrhea, leg pains, incoordination, visual disturbances, motor and sensory paralyses, extension tremor, muscular twitchings of the face, and exaggerated reflexes. When the tenth cranial nerve is involved, there is difficulty in swallowing. Irritation of the kidneys may yield oliguria, albuminuria with casts, and often hematuria and phosphaturia. Delirium and hallucinations often occur.

The most characteristic acute cases show central nervous system signs, such as tremors, convulsions, and motor paralysis. The early signs of rhinorrhea and conjunctivitis are often misinterpreted as coryza. Conjunctivitis, ptosis of the eyelids, and scotoma are common complaints. There may be an elevation of blood pressure, tachycardia, and oppression of the chest, and the breath may have a foul garlicky odor. Respirations may become dyspneic and pneumonia often occurs late.

Examination of the blood frequently reveals an eosinophilia. In prolonged cases, calcium may be mobilized, resulting in an increase of calcium level

From the Pediatric Division of the Robert B. Green Memorial Hospital and the University of Texas Postgraduate School of Medicine.

in the blood and a deposition of calcium in sections of the body which show injuries in the form of necroses or hemorrhage. Spectroscopic examination of the urine does not always reveal the presence of thallium.

TREATMENT

The treatment of thallotoxicosis has not been satisfactory. Some physicians have advocated using sodium iodide to fix the thallium within the body tissues. This is then followed by daily intravenous administration of 20 cc. of 3 per cent sodium thiosulfate to permit gradual elimination of thallium. Others believe that BAL, 3 mg. per kilogram of body weight, is of greater value, especially if given early.

Recently, 2 patients, siblings, with thallium poisoning were admitted to our care. The case histories of these 2 children, plus 1 case which illustrates the necessity for accurate history, are presented.

CASE REPORTS

CASES 1 and 2.—K. C., 4 year old white girl, was admitted to Robert B. Green Pediatric Service on September 8, 1954, after having been seen in the Emergency Room. According to the history, the mother noticed small white blisters on the child's lips on August 30. The following day, the child complained of a severe headache; the blisters had spread to the buccal mucosa. The patient became increasingly irritable, had crying spells, and refused to eat. On September 1, she complained of fever, sore throat, and coryza. She was taken to her family physician, who gave her "sulfa" tablets. That evening, she complained of pain in the abdomen and extremities, and ataxia developed. On September 3, five days prior to admission, she had great difficulty in coordination, the gait was staggering, the voice jerky. It was also noted that the hair was beginning to fall out on the pillow and that it came out in great quantities when brushed. The child was constipated and weak.

On admission, she had alopecia except for a small fringe about the forehead; all reflexes were hyperactive. She had severe tremors and refused to talk. She cried out in pain when her extremities or abdomen were touched. Her temperature was 99 F., and her past history was not remarkable.

Laboratory studies are summarized in table 1.

TABLE 1.—*Laboratory Data on 4 Year Old Girl with Thallium Poisoning (Case 1) on Admission to the Hospital.*

Chest roentgenogram	Negative
Urinalysis—	
White blood cells	15-20 per high power field
Specific gravity	1.025
Negative for thallium	
Complete blood count—	
White blood cells	7,200 per cu. mm.
Hemoglobin	10.8 Gm. per 100 cc.
Basophils	1%
Eosinophils	6%
Segmented cells	42%
Lymphocytes	50%
Myelocytes	1%

J. C., 3 year old brother of K. C., also was admitted to Robert B. Green on September 8, 1954, with a history of a sore throat and coryza on August 31, for which he was given "sulfa" tablets by his family physician. One week prior to admission, he began to be increasingly irritable and to complain of back and leg pain. He became "very wobbly" in his gait and fell frequently. Anorexia and drowsiness developed, and his hair began to fall out in large quantities. Two days prior to his admission, he developed tremors of his extremities and ceased to talk. On admission, he had a temperature of 100 F., alopecia, hyperactive reflexes, positive Romberg signs, and ptosis of both eyelids.

A study of his past history revealed that he was a premature infant and that he had pylorospasm which was treated successfully with atropine drops. Laboratory data on admission are given in table 2.

TABLE 2.—*Results of Laboratory Studies on Admission of 3 Year Old Boy with Thallium Poisoning (Case 2) to the Hospital.*

Urinalysis—	
White blood cells	3-7 per high power field
Specific gravity	1.001
Negative for thallium	
Complete blood count—	
White blood cells	8,000 per cu. mm.
Hemoglobin	11.6 Gm. per 100 cc.
Segmented cells	79%
Lymphocytes	20%
Myelocytes	1%

Careful questioning of the mother revealed that she had seen the children near some Kern's Roach Poisoning (3 per cent thallium) two and a half weeks prior to beginning symptoms. She did not know if they had eaten any. She also recalled that their three cats recently had become ataxic and lethargic, had lost their hair, and suddenly had died.

Case 1 was treated with BAL, 3 mg. per kilogram of body weight, every six hours for 8 doses (0.4 cc. per dose). There was an exaggeration of all symptoms. Another 8 doses were given. As her temperature rose to 101 F., Gantrisin, 1 teaspoonful every six hours, was given for five days. She became afebrile on the second day. The third day after treatment was initiated, she began to eat and show interest in her surroundings. She was discharged from the hospital on September 20 considerably improved.

Patient 2 was treated with a 10 per cent solution of sodium iodide, 5 cc. intravenously at 8 a. m. the day following admission. At 4 p. m. he was given a 3 per cent solution of sodium thiosulfate, 10 cc. intravenously with 100 cc. of 5 per cent glucose in distilled water with 2 cc. of Betaline and 10 mg. of ascorbic acid daily for four days. He improved steadily and was discharged from the hospital September 20 to be followed in the clinic.

Both of these children are being seen weekly at the clinic. J. C. has been improving much more rapidly than his sister. The hair of both children is slowly returning. Both are eating and playing well, but K. C. has periods of extreme irritability accompanied by tremors. K. C.'s tremors appear when she becomes fatigued.

CASE 3.—R. H., a white 3 year old girl, was admitted to Robert B. Green Hospital on October 31, 1954, having been referred by the family physician with the diagnosis of nitrate poisoning. She was reported to be well until October 28, at which time she drank a bottle of Baby Percy. She had loose, yellow stools that night and began to vomit. She refused to eat and developed a staggering gait. The following day, the mother gave her "a large dose of castor oil." She rapidly became worse, was drowsy, and finally could not be aroused. Episodes of delirium developed.

On admission, she was semicomatose but at times was frankly delirious. Her temperature was 98.6 F.; her pupils were dilated, tonsils large, reflexes normal; many ronchi and rales were in her chest, and a thick mucus was in her throat (diagnosis of encephalitis, methemoglobinemia, or

metabolic acidosis was made). A mass was felt above the manubrium which on palpation had a thrill.

She was placed in an oxygen tent and intravenous fluids were started. Laboratory studies were made on October 31 and November 1 (table 3). On November 1, she had

TABLE 3.—*Laboratory Studies Made October 31 and November 1, 1954, on a 3 Year Old Girl (Case 3) Who Had Taken Roach Poison Three Days Previously.*

October 31, 1954	
Nonprotein nitrogen	47 mg. per 100 cc.
Complete blood count—	
Red blood cells	4,240,000 per cu. mm.
White blood cells	14,000 per cu. mm.
Hemoglobin	11.2 Gm. per 100 cc.
Stabs	3%
Segmented cells	58%
Lymphocytes	38%
Myelocytes	1%
Spinal tap—	
White blood cells	2 per cu. mm.
Lymphocytes	2%
Sugar	65 mg. per 100 cc.
Protein	10 mg. per 100 cc.
Methemoglobin	Negative
Carbon dioxide	43 vol. per 100 cc.
November 1, 1954	
Blood studies—	
Salicylates	1 mg. per 100 cc.
Carbon dioxide	22.4 mg. per 100 cc.
Glucose	145 mg. per 100 cc.
Chest roentgenogram	Findings suggestive of extensive interstitial type pneumonia

great respiratory distress, and a tracheotomy was performed and a gavage tube inserted for feeding. Antibiotics were started. On November 2 at noon, the parents informed us that the child had taken roach poisoning. The respirations by this time were very poor and the color cyanotic; she died at 5 p. m. At autopsy an extract of the brain, muscle, liver, and spleen was positive for thallium.

SUMMARY

The increasing incidence of thallium poisoning in Texas and the symptoms of this accidental poisoning in children are discussed. Case histories of 2 siblings with chronic poisoning and of 1 child with acute poisoning with fatality are presented. The necessity for keeping poisons out of reach of children is stressed, and the present treatment for thallium poisoning is reported. During the preparation of this report, 6 other cases of thallotoxicosis being treated by local pediatricians have been brought to our attention. At the present time, 1 patient is in the Robert B. Green Pediatric Service, having been admitted with the complaint of increasing alopecia. Thallium poisoning has not been confirmed by laboratory tests, but there is a history of ingesting rat poisoning containing thallium.

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Steed Stomps Sawbones

This racy item is an early report of the activities of the Uvalde-Edwards County Society:

"Secretary C. R. Myrick has just recovered from the effects of painful, though fortunately not serious, injuries

resulting from a kick on the abdomen received during an encounter between himself and his trotting stallion, Bucephalus. It seems that Bucephalus had escaped from his stall and set out to make some Fourth of July calls. Dr. Myrick arrived on the scene while he and a neighbor were discussing the boll weevil question or perhaps arguing some point of Equine Ethics. Bucephalus 'sponded to the Doctor's 'howdy' with a vigorous kick in the left lower quadrant. The Doctor took the count and Bucephalus took to the tall timber. Fortunately Drs. Watt, Bowman and Hines on the way home from choir practice were passing at the time. They accompanied Dr. Myrick to his home and assisted him in removing the prickly pear needles. Bucephalus, Dr. Myrick thinks, has never recovered his good humor since the House of Delegates at the Houston meeting declared in favor of journalizing the transactions. It is thought that he being unable to write upon the subject, took the above described means of expressing his disapproval."—Texas State J. Med. *1*:117 (Sept.) 1905.

DOCTORS' INCOMES—1907

In 1907, Dr. I. C. Chase, Secretary of the Texas Medical Association, published in the JOURNAL the results of a survey made among 3,317 practitioners in 79 Texas counties. Of these, 55 per cent reported that they were making a bare living; 45 per cent managed to save something. The highest medical income reported in the state was $40,000, but the average income was only $1,873; the average expense, $1,301; and average annual savings only $572.—Texas State J. Med. *3*:62 (June) 1907.

ENTER THE LADIES

Heralding one of the early state meetings of the Woman's Auxiliary to the Texas Medical Association was this item in the JOURNAL (1:419 [April] 1920):

"It will be noted in the Announcements that the Woman's Auxiliary will hold several business meetings during the annual sessions. This is a matter of more than passing interest to our members, and it is to be hoped that they will see to it that their wives (at least one wife for each member) and daughters (not to mention sweethearts) are given full opportunity to attend."

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194 Miles of Medical Reporting

Intercommunication and a permanent recording of group action is essential to the development of a cohesive organization. The physicians who established a statewide professional society in Texas recognized this and began publishing, in one form or another, reports of their annual conventions to jog the memories of those who were present and to edify those who were not. Throughout the stumbling period of the infant association, beginning with the first meeting in 1853, the Proceedings or Transactions were printed usually as separate volumes paid for out of membership dues, although for a time efforts were made to include this material in a private medical periodical. Most volumes of Transactions included an account of the meetings of the House of Delegates and of the general assemblies, a roster of members and of officers and committees, the Constitution and By-Laws, the Principles of Medical Ethics, and most of the scientific presentations from the session.

The idea of an official periodical which could record the events of the annual convention and serve between sessions as a purveyor of Association news, legislative information of special concern to physicians of the Lone Star State, items about doctors, and scientific advances seems to have been considered by some members of the Texas State Medical Association at least 25 years before the turn of the century. However, it was not until the Association adopted a new Constitution providing for membership through component county medical societies and sizable growth seemed possible that the voices favoring a journal made themselves heard to any appreciable degree.

With acceptance of the new organizational plan, the State Medical Association increased its membership from 368 in 1903 to 2,393 in 1904, and a year later the Secretary pointed out that Texas was seventh among states of the United States in the number of physicians (4,826), fifth among the states in the number of members of the state medical society, twelfth in the percentage of membership to total physicians (49.5 per cent). As the Secretary, Dr. Ira C. Chase of Fort Worth, pointed out at the 1905 meeting of the Association in Houston, "it was a mistake to try to run a 2500-member association on a 400-member plan." He continued:

". . . Our present methods are inefficient because we are doing little for our members. As long as we feed them on stale Transactions and nothing more, in my opinion, they will never grow. . . . The solution of our ineffectual plans and unsatisfactory business methods, I believe, is to be found in the establishment of a State Journal, for the following reasons:

"1. It will provide a means of intercommunication.

"2. It will publish our Transactions while fresh.

"3. It will increase our educational power among the profession and the laity.

"4. It will diminish the labor of Councilors.

"5. It will stimulate life and interest in county societies.

"6. It will affiliate more closely District Societies and complete professional unification.

"7. It will make advertisers help pay our expenses.

"8. It will furnish transportation to Councilors where now we pay their cash fares.

"9. It will enable us to hire done the clerical work of the Association.

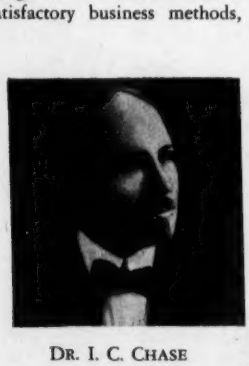
"10. It will enable us to put by a goodly sum to expend on legislative and educational reforms, libraries, museums, hospitals and other monuments to our beloved profession." (Texas State J. Med. *1*:20 [July] 1905.)

The same viewpoint was evident in the report of the chairman of the Councilors, Dr. W. B. Russ of San Antonio: "The Councilors are unanimous in their opinion that the life of county societies, especially those in isolated sections, absolutely depends upon the establishment of a medium of communication of such as a State journal would afford." (Texas State J. Med. *1*:21 [July] 1905.)

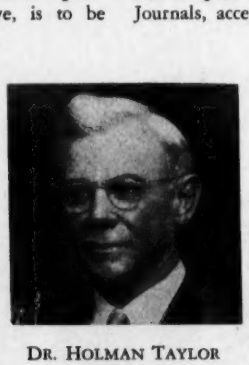
Investigation by a special Committee on Publication consisting of Dr. W. R. Thompson of Fort Worth, chairman, and Dr. Chase, indicated that 15 other state medical organizations conducted medical journals and that only five states besides Texas which were organized under the American Medical Association with more than 1,000 members did not "journalize their transactions," a method found to be cheaper for the larger organizations. The committee continued its report at the 1905 session with definite recommendations and reasons therefor:

"To accomplish the best work a journal must be absolutely free and untrammeled by fear of subscribers or avarice of advertisers. Professional interests must always precede dollars. We believe the Journal can not fill the place it should if limited to the horizon of individual ownership, but that it should be published in the wide interest of organized Texas medicine and be owned by the Association from the title page to the back cover.

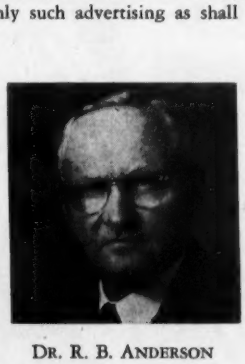
"We advise that the advertising conform to the standards adopted by the American Association of State Medical Journals, accepting only such advertising as shall state the



DR. I. C. CHASE



DR. HOLMAN TAYLOR



DR. R. B. ANDERSON

names and quantities of constituent parts of remedies advertised; further, such products must not be advertised to the laity through the secular press. . . . We advise the size and style of this journal conform to that adopted by New York and California, and its name to be THE TEXAS STATE JOURNAL OF MEDICINE. We recommend at first to issue a forty-eight-page paper, sixteen pages of which to be advertising and thirty-two pages reading matter. A paper of this size will print 2.2 times our 1904 Transactions. It will allow seventeen pages for Transactions and fifteen pages for contemporary matter in each issue.

"We recommend that $1.00 be set aside from the membership fee of each member as a subscription for this JOURNAL, and the subscription price to nonmembers be $3.00 per year. We believe the JOURNAL can be most economically published when the Secretary and editor are one. . . .

"Your committee advises this JOURNAL to be published under the control and direction of the Board of Trustees, that the Councilors be made associate editors, and that the efficiency of the JOURNAL be further increased from year to year by the appointment of special committees, to gather facts and publish, under the direction of the editor, articles on important questions." (Texas State J. Med. *1*:67-68 [Aug.] 1905.)

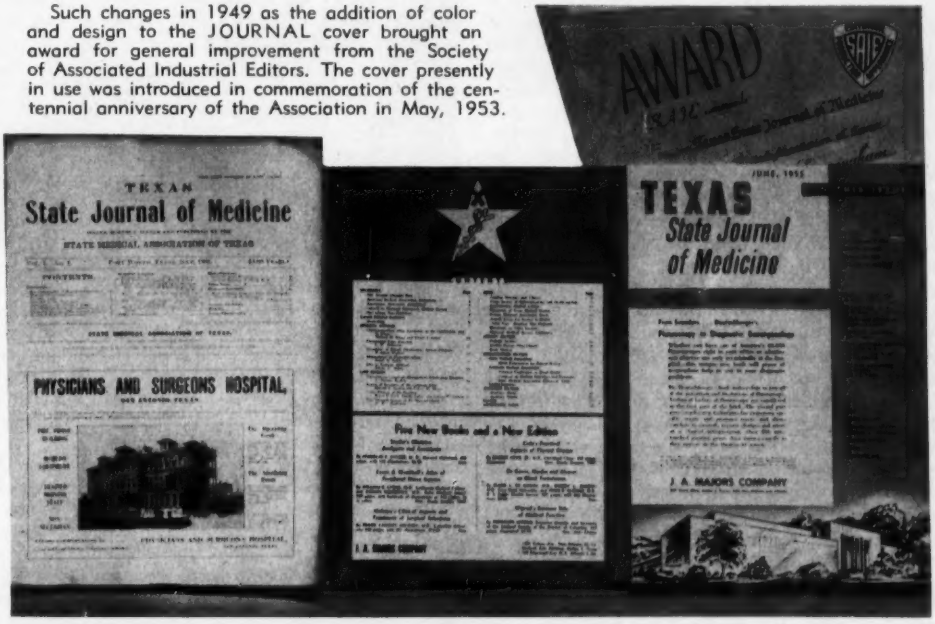
After discussion of the committee's recommendations Dr. Holman Taylor of Marshall spoke: "I move that this House of Delegates adopt in lieu of their annual proceedings a journal of monthly form and of such details of workings as will be instituted by our Board of Trustees." Duly seconded and discussed at length, this motion carried without a dissenting vote.

So it was that volume 1, number 1, of the TEXAS STATE JOURNAL OF MEDICINE rolled from the presses of the Von Boeckmann-Jones Company in Austin in July, 1905.

The first issue of the JOURNAL, of which 3,700 copies were printed, conformed in large measure to the suggestions of the Committee on Publication. It consisted of 16 pages of advertising, half in front and half in back, with 44 pages of reading matter of which 12½ were a membership roster and 5 were the first installment of official transactions. Eight editorials and six original articles were included, the latter by "Thomas Esculapius," John S. Turner of Terrell, A. C. Scott of Temple, E. H. Cary of Dallas, C. A. Smith of Texarkana, and W. L. Brown of El Paso. The masthead carried the name of Ira Carleton Chase as Editor-in-Chief with S. T. Turner, El Paso; L. A. Grizzard, Abilene; D. R. Fly, Amarillo; C. M. Alexander, Coleman; W. B. Russ, San Antonio; H J. Hamilton, Laredo; T. J. Bennett, Austin; Green Davidson, Wharton; John T. Moore, Galveston; B. F. Calhoun, Beaumont; S. R. Burroughs, Buffalo; G. B. Foscue, Waco; J. H. McCracken, Mineral Wells; M. Smith, Sulphur Springs; and Holman Taylor, Marshall, as Associate Editors and Councilors. Names of the President, Secretary, Treasurer, and Board of Trustees of the Association were listed on the front, which carried the table of contents, a half-page advertisement of the Physicians and Surgeons Hospital of San Antonio, and second class mail and copyright notices.

Despite occasional ups and down the TEXAS STATE JOURNAL OF MEDICINE has continued regular monthly publication this half century. Dr. Chase's energy and ability for five years set the pattern on which the periodical has built its reputation; he relinquished his editorial pencil with the May, 1910, issue to devote more time to his medical practice. Named as his successor as Editor-in-Chief and Secretary of the Association was Holman Taylor, the Councilor from Marshall whose motion gave birth to the JOURNAL. Dr. Taylor, a forthright East Texan imbued with zeal for the medical profession, moved to Fort Worth, where Dr. Chase had set up editorial offices, and guided the affairs of the JOURNAL from June, 1910, until his death in De-

Such changes in 1949 as the addition of color and design to the JOURNAL cover brought an award for general improvement from the Society of Associated Industrial Editors. The cover presently in use was introduced in commemoration of the centennial anniversary of the Association in May, 1953.



cember, 1947. An exception was the period from August, 1916, to April, 1920, when Dr. Taylor was on active duty with the United States Army and Dr. Chase filled in as Editor-Pro-Tem. Dr. D. R. Venable became the first Assistant Secretary-Editor in 1924 and served until 1927. From 1927 until January, 1947, when death stilled his pen, Dr. Reuben B. Anderson, Jr., able Assistant Secretary-Editor, bore an increasingly large portion of the JOURNAL burden, working effectively though sometimes explosively with his capable chief.

Following Dr. Taylor's death, the JOURNAL masthead showed as editors Dr. Harold M. Williams (December, 1948-April, 1950) and Mr. Tod Bates (August, 1950-June, 1951). Since that time the masthead has carried as its highest editorial title "assistant editor" and then (since July, 1952) "managing editor" with Miss Harriet Cunningham, a trained journalist who joined the editorial staff in 1945, in that position. Other members of the editorial staff in July, 1955, are two editorial assistants, Miss Betty Segal and Mrs. Rachael W. Murphey, and a stenographer, Mrs. Dean E. Little.

Mention is made in the records of the appointment in 1919 of a half-time advertising manager for the JOURNAL. In 1923, Miss Anna Keith was employed to assist with the advertising as well as handle the increasingly complex bookkeeping of the Association and in 1947 was made advertising manager. Upon Miss Keith's retirement in the fall of 1953, Mr. E. Maxwell Jones, an accountant, became business manager of the Association and advertising manager of the JOURNAL. Assisting with the advertising at present are Miss Mildred Whiteman, who has been on the staff since 1946, and Mrs. Martha Estep.

Mr. C. Lincoln Williston, Executive Secretary of the Association, supervises the JOURNAL operation as well as all other activities of the Association's headquarters staff. Others on the 24-member staff contribute to the over-all production of the JOURNAL in such ways as providing copy on the Library, keeping the mailing list up to date, and doing odd jobs of typing, just as the editorial and advertising personnel assist with organizational matters having no direct connection with the JOURNAL.

Since its inception, the JOURNAL has been in the final analysis the responsibility of the Board of Trustees—its Board of Publication—and policy decisions remain in the hands of that body. The district Councilors, originally named as associate editors and listed with that heading up to the October, 1917, JOURNAL, no longer have an organic relationship with the JOURNAL, but they are called on at varying intervals for advice and assistance. Informally before that time and with definite design since about 1948, physicians throughout the state have been named as editorial consultants. These physicians, their names kept confidential to permit the greatest objectivity, review scientific papers submitted for publication, checking them for medical accuracy, evaluating their suitability for the JOURNAL, and recommending action.

In 1951, when the Association placed the management of its central office in the hands of a nonphysician, the first JOURNAL advisory committee was named to meet periodically with the staff, weigh each paper on its merits and against other available material, and advise with respect to all scientific aspects of the periodical. This committee, composed of six Austin physicians representing several specialty fields and with overlapping three-year terms of office, serves under the Board of Trustees. Anonymous except to the Trustees and staff, the advisory committee performs a far-reaching service in its efforts to coordinate and keep high the standards of excellence of the scientific contributions in the JOURNAL and in its readiness as a committee or as individual members to confer with staff members regarding publication problems of whatever nature.

After the April, 1909, issue of the JOURNAL, its printing was transferred from Austin to Fort Worth, where first the Reimers Company (May, 1909-April, 1920) and then its successor the Stafford-Lowdon Company (May, 1920-date) have produced and mailed the periodical. Satisfactory arrangements were made to continue printing in Fort Worth when the editorial offices were moved with the Association headquarters from Fort Worth to Austin in 1948, and photoengraving of illustrations also continues to be handled in Fort Worth by the Worth Engravers, which has provided cuts for the JOURNAL since 1933.

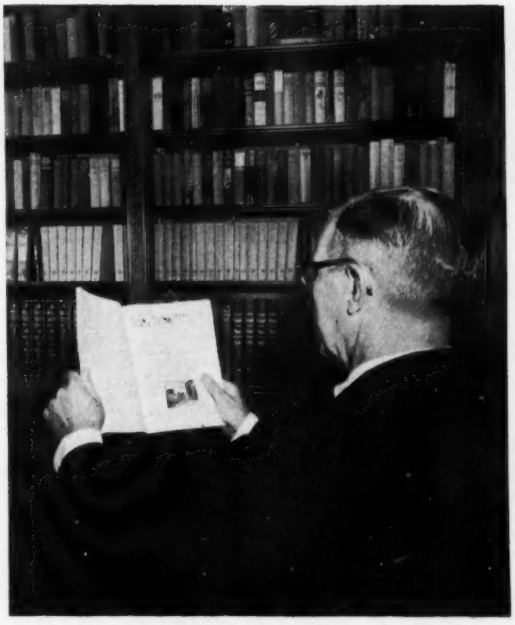
The format and typography of the JOURNAL had not changed much from the first issue through 1948, although the page size had been modified slightly to conform with pages of other state journals cooperating in the State Journal Advertising Bureau operated by the American Medical Association and a buff colored enamel cover had replaced the thinner paper which protected early issues. The January, 1949, issue began a new volume changed to a January-December cycle to match the Association's membership and fiscal years instead of following the former May-April cycle established in connection with annual conventions. It also departed from previous issues with the use of a blue border and special design (rod of Esculapius inside a star) on the cover and a new type for reading pages, the new type being chosen for readability and to relieve with greater use of white space and heavier headings a monotonous grayness which had predominated previously. A different cover featuring the recently occupied Association building appeared with the May, 1953, issue.

The number of pages in the JOURNAL, although stabilizing at various plateaus during the intervening years and affected by such factors as paper shortages during war years, has increased to the point that 132 pages, approximately half reading matter and half advertising, is considered normal for an issue. With increased size, a press run of about 7,000 copies per issue, and greater production cost, the JOURNAL budget has grown from an initial item of less than $10,000 annually to more than $60,000. With $1 originally allocated per $2 dues, the JOURNAL continues to depend upon membership dues for roughly one-third of its revenue, the allocation now and since 1927 being $3 per member. The subscription rate for nonmembers is again $3 per year, identical with the rate in 1905. Somewhat more than two-thirds of the JOURNAL'S revenue is from advertising, much of it from firms doing national business but a sizable amount from Texas accounts.

Thus the TEXAS STATE JOURNAL OF MEDICINE moves along in its fifty-first volume, "devoted to the interests of the medical profession and public health in Texas."

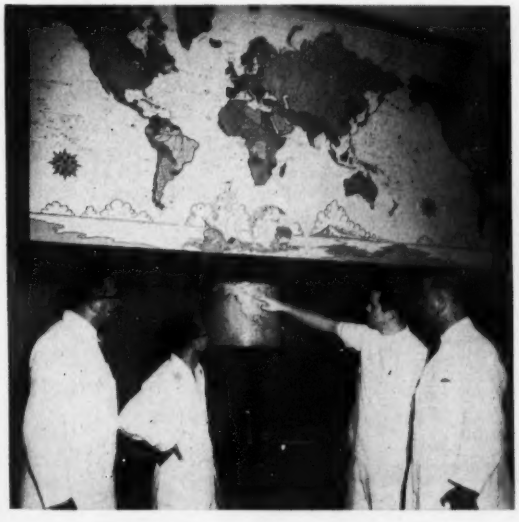
REFERENCES

1. Nixon, P. I.: History of Texas Medical Association, 1853-1953, Austin, University of Texas Press, 1953.
2. Texas State Journal of Medicine, vol. 1, no. 1-vol. 51, no. 6, July, 1905-June, 1955.



In the comfort of his own study, a doctor reads the editorials in an issue of the JOURNAL. Soon this issue will be added to others and bound for permanent keeping. The annual index in each December issue insures ease of reference to scientific articles and other material published, furnishing the physician with a valuable source of information on medical matters for years to come.

The international students below who teach and study at the University of Texas Medical Branch, Galveston, will be able to read the JOURNAL in libraries in their native lands when they return home. They are Dr. Jorge Labal Ceballos, Mexico City, Mexico; Dr. Mitio Niizima, Tokyo, Japan; Dr. John Brooks Fotheringham, Montreal, Canada; and Joao Brito Jorge, D.V.M., Rio de Janeiro, Brazil.



Mr. R. K. Kimbrell, assistant director of public relations, and Miss Annabelle Jourdan, public relations secretary, of Blue Cross-Blue Shield of Texas, check the original layout and wording of their advertisement with the finished product as it appears in the JOURNAL. Mr. Kimbrell does the art work for Blue Cross-Blue Shield advertisements used in the JOURNAL.

Where the Journal Goes

The approximately 7,000 TEXAS STATE JOURNALS OF MEDICINE which are distributed each month travel not only to the almost 7,000 members of the Texas Medical Association, but also to schools, libraries, and editors throughout the United States and the world.

Within the continental United States, 193 JOURNALS are distributed in exchange for other medical and technical publications for the Association's Memorial Library and other Texas medical libraries. Sixty-five of these JOURNALS are placed in medical libraries in states other than Texas; they include the libraries of medical schools, hospitals, medical societies, and other groups.

Each month, several JOURNALS are destined to reach libraries and scientific editors on every continent. In exchange for foreign medical journals, 58 copies of the JOURNAL are sent to 26 other nations.

In addition to the members of the Association who receive the JOURNAL and to those on the exchange list, 310 individual subscribers receive the JOURNAL monthly.

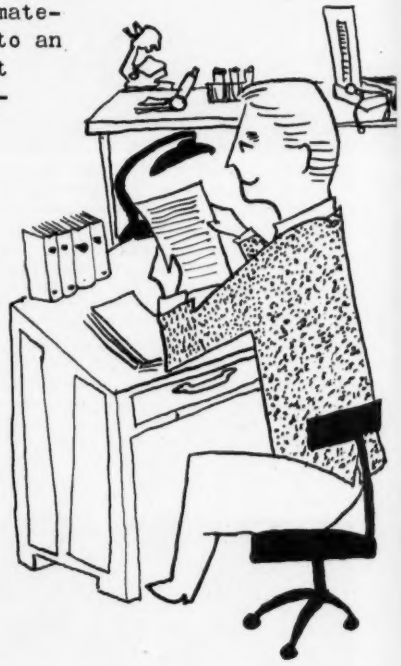
On the business side, advertisers must be considered when making out each mailing list; copies of the JOURNAL are sent for their approval. If an advertising agency handles the work, both the advertiser and the agency receive sample copies. Though the figure varies from month to month, about 100 advertisers and 50 agencies are included.

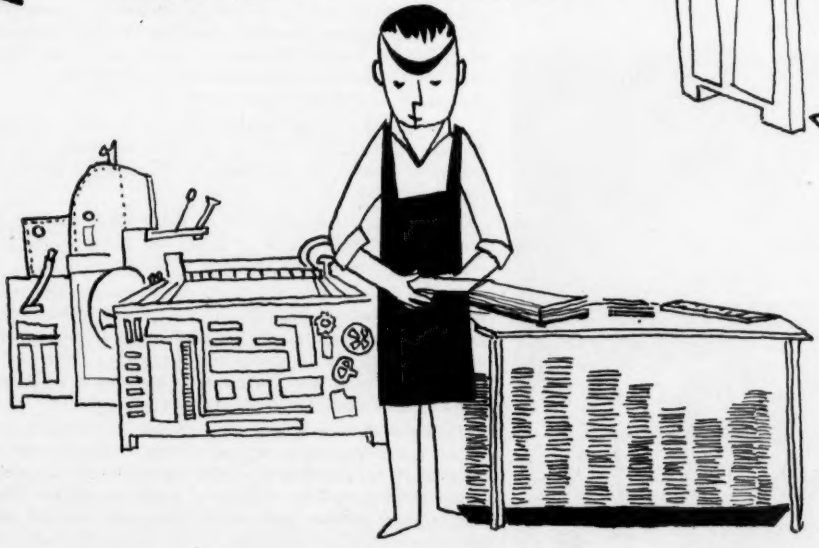
Some complimentary copies are mailed each month; they go to potential advertisers, publishing companies whose books have been reviewed in that issue and are deposited in the Library, families of deceased physicians whose obituaries appear in the issue, and to a few miscellaneous recipients.

FROM YOU...

the officers and members of the Texas Medical Association and the Woman's Auxiliary, comes scientific articles, news, and other information published in your monthly Journal.

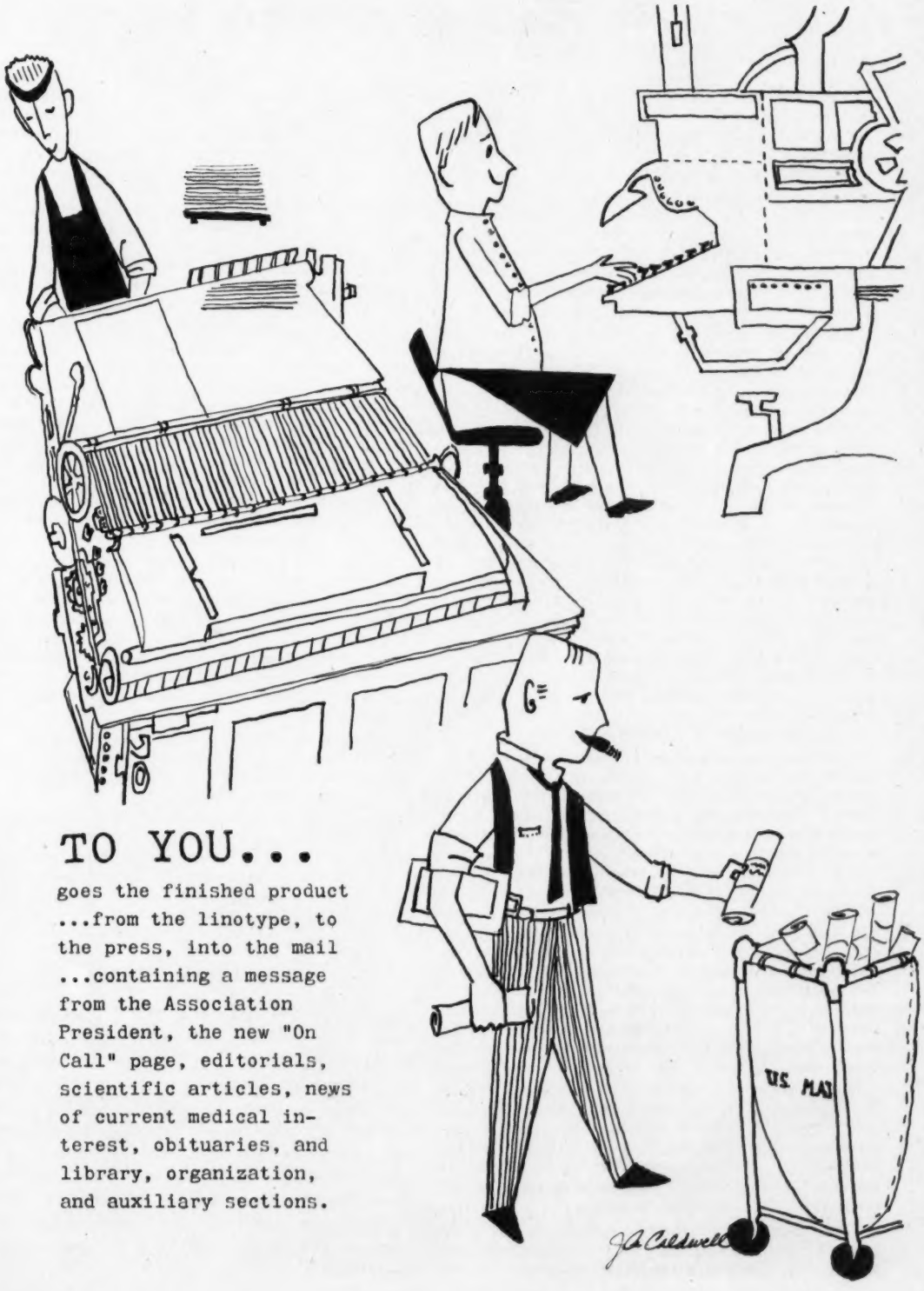
Mail plays an important part in each issue of the Journal. Incoming material often is sent to an editorial consultant (right) for his recommendations and advice...to the printer goes the copy and the engraver receives the illustrations. The author (left) rechecks his material in its printed form before it is released for publication.





Some of the many sources of obtaining information for the Journal: telephone...meetings.. correspondence... contributions from physicians, their families, and the Memorial Library staff...newspaper clippings and news releases. Contributions are always welcome as are suggestions and comments.

After scientific articles are reviewed by editorial consultants from throughout the state, the decision as to their suitability for publication is left to an editorial advisory committee. Papers are processed with emphasis on accuracy ...references are verified and the material is checked.



TO YOU...

goes the finished product ...from the linotype, to the press, into the mail ...containing a message from the Association President, the new "On Call" page, editorials, scientific articles, news of current medical interest, obituaries, and library, organization, and auxiliary sections.

The Role of Advertising

Advertising plays a vital role in the production of the JOURNAL; were it not for advertising revenue, which pays for nearly four-fifths of the production costs, the JOURNAL could not exist.

Placing an advertisement in the JOURNAL, however, is not so simple an operation as it might seem to the uninitiated reader. To assure strictest accuracy and to protect physicians from exposure to unwarranted claims by manufacturers, all products advertised in the JOURNAL must be approved by medical councils at the national, state, or local level, depending on the type of advertising which is proposed.

All national advertising is contracted for through the State Journal Advertising Bureau, a non-profit agency of the American Medical Association. Those products advertised are examined and reviewed by the appropriate council of that association. The principles governing the eligibility of drug mixtures for advertising are an indication of the thoroughness of this examination. In general, only mixtures containing not more than two active ingredients are eligible. All active ingredients of mixtures must have been evaluated by the Council on Pharmacy and Chemistry and found to be of established value, and there must be a logical rationale for the inclusion of each of the active ingredients in any particular mixture. The dosages of each ingredient must be generally recognized as adequate and appropriate for the individual needs of most patients. A quantitative statement of composition, insofar as the active ingredients are concerned, must appear in every advertisement. Claims made must not encourage irrational therapy or exceed those which are recognized by the council for each active ingredient. Claims involving such matters as synergistic activity and decreased toxicity must be well documented by adequate scientific evidence.

In addition to thorough testing and examination of the product, the proposed copy for the advertisement is reviewed by the Advertising Committee of the American Medical Association. Only after products and the advertisements of these products have passed the AMA's rigid screening and have been officially accepted by the State Journal Advertising Bureau can they be presented to Texas doctors on the pages of the JOURNAL.

Local advertising, if it is of a scientific nature, must be approved by the proper council of the Texas Medical Association; nonscientific advertisements are referred to the county medical societies for their recommendations. Classified advertisements and professional cards are available to members of the Association upon request, but professional cards are not sold to nonmembers, and classified advertisements of nonmembers must be checked and approved by the county medical society of their residence before acceptance.

It is the policy of the JOURNAL to maintain the highest professional standards obtainable in the publication of local advertising and to conform with the standards set for national advertising. While the JOURNAL is not in a position to endorse the materials advertised in its pages, it is the intention to obtain adequate professional and scientific supervision to serve and protect its readers.

The process of double checking both the product to be advertised and the claims made for it has not always been in effect. The question of advertising matter was raised in the House of Delegates of the Association during the annual session in 1909. The Trustees reported that the American Medical Association was striving to raise the standards of advertising which appeared in the pages of its journal and was urging state associations to do likewise. "This has been met with strenuous opposition," the report read, "by patent medicine men, proprietary interests and unscrupulous rascals who would deceive and harm the innocent public with inert or dangerous remedies. . . . It is almost inconceivable that men will thus traffic in human life and maliciously deceive innocent and unfortunate sufferers for the purpose of piling up vast tainted fortunes."

The report also commended the AMA for the formation in 1905 of the Council on Pharmacy and Chemistry, which at the time was investigating and reporting as rapidly as possible on proprietary pharmaceuticals and publishing formulas so that doctors could tell whether remedies were valuable or fraudulent and inert. As the results of chemical tests became known, the *Journal of the American Medical Association* and state journals including the TEXAS STATE JOURNAL OF MEDICINE began refusing renewals of advertising contracts for fraudulent drugs and began accepting only the advertisements of remedies proved by test to be chemically active and valuable.

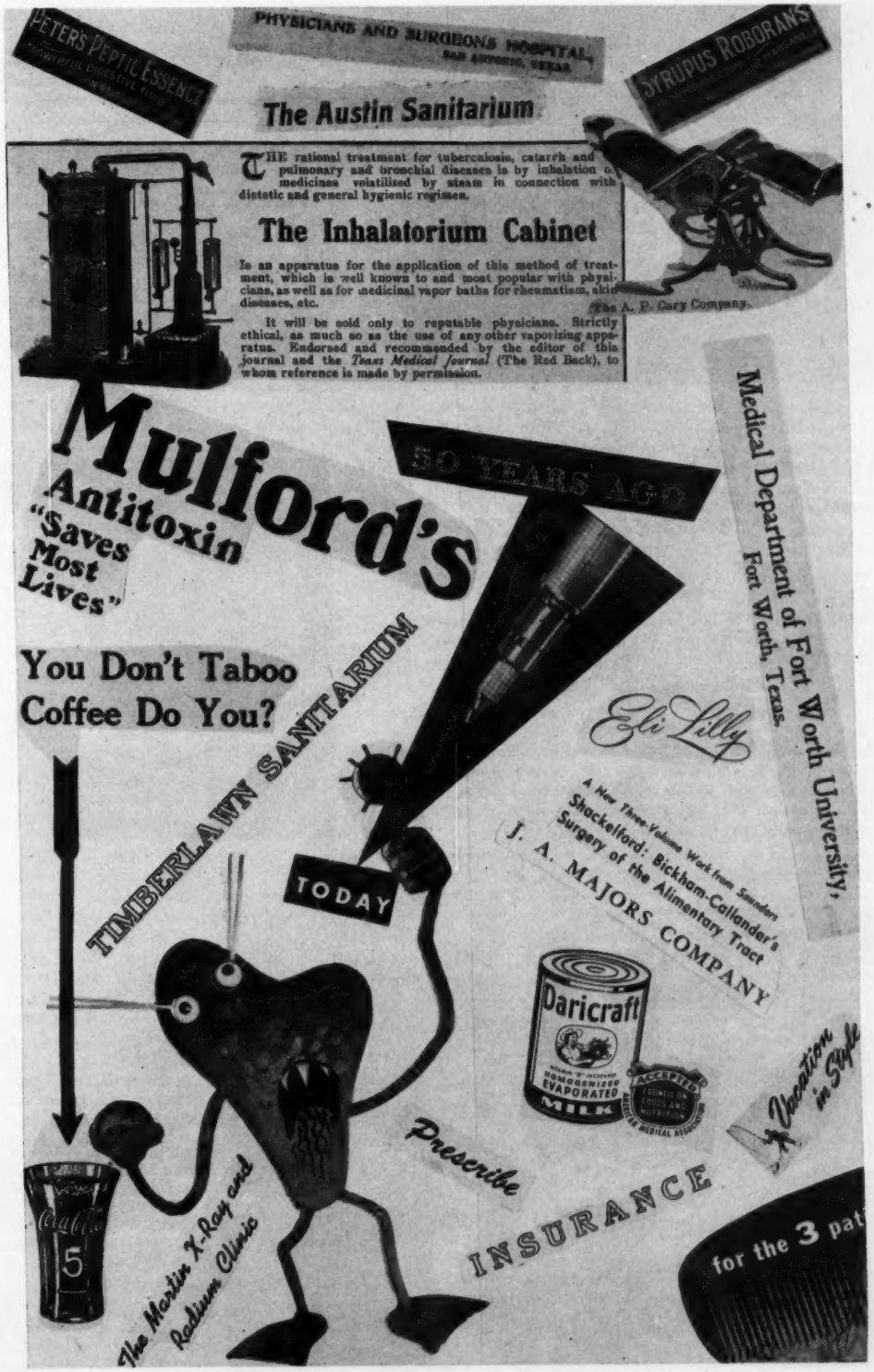
In the 1909 report, the Trustees stated, "In our judgment there is only one thing for the JOURNAL to do, and that is to stand squarely upon the basis laid down by the American Medical Association and fight it out to a finish. It is reasonable, it is right, and it is for the best interests of the profession and the public. Not only have we been successful in finding plenty of advertising matter of the right kind, but the JOURNAL is on a sounder and stronger basis than ever."

Such was the beginning of controlled advertising, and, through the pages of reputable medical journals, of protection of doctors from unethical and unfounded advertising claims for worthless remedies.

In the TEXAS STATE JOURNAL OF MEDICINE, the amount of advertising has been increasing for several years, and it is defraying a larger and larger portion of production costs. This trend is expected to continue, but care is being exercised to avoid impairing readability or lowering the standards by which advertising is accepted.

How Many Pages?

In fifty years of publication, 34,570 pages of reading matter and 27,590 pages of advertising have appeared in the TEXAS STATE JOURNAL OF MEDICINE. From July, 1905, through June, 1955, there were 5,120 scientific papers published in the JOURNAL, with extremes being in 1907, when only 54 articles were included in volume 3, and in 1928 (volume 24) and 1930 (volume 26), each year including 142 papers. The greatest number of original articles published in a single issue was 17, in December, 1928, and again in August, 1941; only 1 paper appeared in 7 issues, the first in May, 1907, and the most recent in March, 1945.


PETER'S PEPTIC ESSENCE
PHYSICIANS AND SURGEONS HOSPITAL
SAN ANTONIO, TEXAS
SYRUPUS ROBORANS
The Austin Sanitarium
THE rational treatment for tuberculosis, catarrh and pulmonary and bronchial diseases is by inhalation of medicines volatilized by steam in connection with dietetic and general hygienic regimen.
The Inhalatorium Cabinet
Is an apparatus for the application of this method of treatment, which is well known to and most popular with physicians, as well as for medicinal vapor baths for rheumatism, skin diseases, etc.
It will be sold only to reputable physicians. Strictly ethical, as much so as the use of any other vaporizing apparatus. Endorsed and recommended by the editor of this journal and the Texas Medical Journal (The Red Back), to whom reference is made by permission.
The A. P. Cary Company.
Mulford's
Antitoxin
"Saves Most Lives"
50 YEARS AGO
TODAY
You Don't Taboo Coffee Do You?
TIMBERLAWN SANITARIUM
Medical Department of Fort Worth University, Fort Worth, Texas.
Eli Lilly
A New Three-Volume Work from Saunders
Shackelford: Bickham-Callander's Surgery of the Alimentary Tract
J. A. MAJORS COMPANY
Daricraft
HOMOGENIZED EVAPORATED MILK
ACCEPTED
Vacation in Style
Prescribe
INSURANCE
for the 3 pat
The Martin X-Ray and Radium Clinic

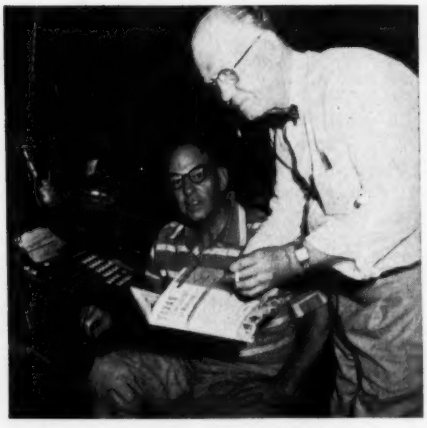
R. R. Lowdon, far left, president of Stafford-Lowdon Company, and his able staff are responsible for the production of the JOURNAL. Many of the company's employees have seen the JOURNAL develop and grow from its very early days. E. W. Webb, below right, plant superintendent, helps guide the JOURNAL material through the mechanical processes to the finished product that goes to the doctors.

The Journal Thanks

The Production Team

Except for the brief period between 1905 and 1909, during which the printer of the TEXAS STATE JOURNAL OF MEDICINE was Von Boeckmann-Jones Company of Austin, the JOURNAL has rolled off the presses of Stafford-Lowdon Company (known as Reimers Printing Company until 1920), one of the largest printing and lithographing companies in the state.

Since shortly after the establishment of the Worth Engravers in 1932, the engravings used in the JOURNAL have been made there. The firm moved into its own building in 1950, taking its place as the largest engraving plant in Fort Worth, and just last year purchased the oldest engraving company in the city.



Seeing that technical illustrations are transposed with the greatest of accuracy to engraving plates for use in the JOURNAL is the responsibility of James H. Lowry, left foreground. He and Lawrence Peterson, right foreground, are proprietors of the Worth Engravers.

CONTRIBUTIONS TO THE TEXAS STATE JOURNAL OF MEDICINE

Material for the Original Articles, Case Reports and Current Editorial Comment sections of the TEXAS STATE JOURNAL OF MEDICINE may be submitted directly to the Editor, 1801 North Lamar Boulevard, Austin, or indirectly as a contribution to the program of the annual session of the Texas Medical Association. Papers presented at the annual session become the property of the Association and may be published in the JOURNAL. An author who wishes to offer his paper to another periodical may apply to the Editor for permission to do so. Whether or not a paper has been presented at an annual session or before any organization does not affect its acceptance for publication in the JOURNAL. Every paper is reviewed by an editorial consultant, considered by an advisory board, and accepted or rejected by the Editor on the basis of its merit and the availability of other material.

Suggestions for handling manuscripts are outlined below.

1. Each contribution should be typed on one side of the paper, double spaced, and with ample margins.

2. Except in unusual instances the length of original articles and case reports should not exceed 2,500 words. Current editorial comments should contain from 300 to 500 words.

3. The title of the paper and the names, degrees, and addresses of the authors should head the manuscript except in the case of current editorial comments, for which the information about authors should conclude the manuscript. The author's mailing address should be at the end of each manuscript.

4. The text of the paper, including case reports, should be in narrative style with complete sentences and few abbreviations, appropriately paragraphed and with subheadings inserted at logical points.

5. Previously published material should be indicated. Short verbatim quotations in the text usually are used without permission, but such material should be quoted exactly, enclosed in quotation marks, and credited by a reference number to the proper bibliographic entry. Extensive textual matter, tables, drawings, charts, or photographs are reproduced only with the permission of the author and original publisher. Written permission from these two sources should be obtained by the essayist and attached to the manuscript.

6. An original article or case report should include a brief and concise summary or conclusion.

7. The reference list for original articles and case reports should contain no more than twenty items and for current editorial comments no more than six. The list should be arranged alphabetically with complete bibliographic information including surnames and initials of all authors, title of article, name of journal or book, volume, inclusive pagination, month, day, and year of publication; and publisher, place of publication, and edition, if the work is a book. The reference list should be numbered consecutively and corresponding numbers inserted in the text where desired.

8. A reasonable number of black and white illustrations may be published with original articles and case reports at the expense of the JOURNAL. Illustrations submitted by the author should be in form for reproduction without expense other than the cost of engravings. If new engravings must be prepared because of error on the part of the author, he may be asked to bear the expense of duplication. If the author wishes the illustrations returned after engravings have been prepared, he should make this request when the paper is submitted.

9. Illustrations should be original drawings in black on white paper or positive black and white photographic prints. They should be kept flat and protected by cardboard and should not be clipped or pinned. The name of the author should be written lightly in soft pencil on the back of each illustration. The top of the illustrations should be marked lightly on the back and marks in the margins should show where they could be trimmed without loss of important material.

10. Descriptive legends should be typed on a separate sheet and numbered consecutively. The appropriate number should be marked lightly in soft pencil on the back of each illustration and inserted at the proper places in the text.

11. Occasionally colored illustrations will be authorized if they are considered of special value to an article and if the author arranges to pay all expenses including photographs or drawings, engravings, printing, and production.

12. Tables should be as concise as possible and should be submitted on separate sheets of paper. Complete headings should be used so that tables are intelligible alone without reference to the text. Column headings in the tables should show the points of similarity, side headings the points of difference. It is desirable to prepare tables in such size that when they are reproduced, all parts can be read horizontally.

13. Proof of each original article, case report, or current editorial comment is sent to the author to check before the material is published. Errors in fact and typographical errors should be corrected, but revision of wording or arrangement should be kept to a minimum because of the cost of resetting type. Proof should be read and returned promptly to the JOURNAL to avoid delay in publication.

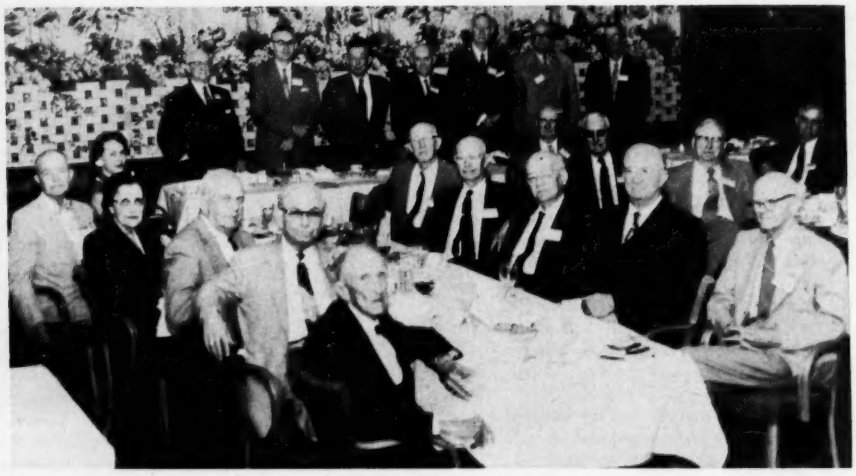
14. Reprints of articles may be obtained at cost provided the author orders them promptly after publication of the paper. Order blanks are mailed to authors upon publication of their articles.

15. Engravings of illustrations used with a paper are available to the author without cost except for shipping charges, provided he requests them promptly after publication of the paper. Order blanks for the engravings are mailed with reprint order blanks.

16. Discussions presented orally at meetings and submitted for publication with the paper should be typewritten, brief, and plainly marked with the name of the essayist and title of the paper discussed and the name and address of the discusser. Illustrations and case reports cannot be published as a part of discussions and bibliographic references must be kept to a minimum. Necessary references should be handled as footnotes and should contain complete bibliographic information.

Contributions of newsworthy items of all sorts are solicited. They should be reported promptly and should include such activities as scientific and business meetings of medical groups, projects of the Woman's Auxiliary, election of officers, appointment of committees, births, deaths, marriages, and civic or professional honors. Who, what, when, where, why, and how should be answered. Correctly spelled names with initials, official titles, home towns, and date of the month instead of day of the week are important. The name and address of the person sending information should be noted.

Deaths of all physicians, whether members of the Association or not, should be reported at once, along with the name and address of someone in the immediate family. County society secretaries will be asked to supply biographical information if obituaries are to be published. Photographs sent in connection with obituaries should be original, recent, and preferably black and white.



Present at the Fifty Year Club's most recent meeting in Fort Worth in April were: Standing, Dr. O. M. Marchman, Dallas; Dr. F. J. L. Blasingame, Wharton, President of the Texas Medical Association; Dr. Walter B. Martin, Norfolk, Va., President of the American Medical Association; Dr. Felix P. Miller, El Paso; Dr. L. H. Reeves, Fort Worth; Dr. B. E. Pickett, Carrizo Springs; Dr. R. G. Baker, Fort Worth, chairman of the Board of Councilors. Left row: Mrs. Beverly Dickerson, Austin; Dr. J. W. Tottenham, Fort Worth; Mrs. J. W. Tottenham; Dr. James Anderson, Brady; Dr. N. A. Elder, Nixon; Dr. John B. Cummins, Fort Worth. Middle row: Dr. James Jernigan, Childress; Dr. Lonnie Cockerell, Waco; Dr. A. R. Shearer, Mont Belvieu; Dr. R. H. Smith, Palo Pinto; Dr. C. L. McClellan, Kerrville. Right: Dr. Paul Stalnaker, Houston; Dr. H. T. Aynesworth, Waco; Dr. E. H. Vaughn, Tyler; Dr. W. L. Baugh, Lubbock.

A Doctor's Education

Dr. Paul R. Stalnaker, Houston, recalls a few of the opportunities he had during and immediately following his years in the University of Texas Medical Branch as being among the most interesting experiences of his life.

Upon completion of his junior year, Dr. Stalnaker was allowed to take the state board examination for his license to practice medicine. He was amazed to learn that he had made the highest grade and had won a prize—a chance to be doctor on a ship, which carried cattle to British possessions in East Africa. While on this trip, he witnessed what he believes to be the first mass inoculation against typhoid fever. Soldiers were being immunized as they returned from the Boer War, and Dr. Stalnaker reported on this project to his fellow students upon his return.

As an outstanding young medical student, he was asked to organize Zeta chapter of Phi Chi medical fraternity in Galveston, which he did in 1903 with seven charter members. He is now president and treasurer of the Zeta of Phi Chi Benefit Association.

After graduation from medical school in 1904, Dr. Stalnaker lacked enough money to pay his way back home to Austin, so he worked as a laborer for $1 a day until he had enough money to buy a new suit, a ten gallon hat, new shoes, and a ticket home. His first professional job, for $5 a day plus room and board, was with the yellow fever commission during an epidemic on the Mexican border. Thus began the career of one physician who has served for more than 50 years in the medical profession.

My First Call

On a dark, stormy June night in 1901, a young Montague County farmer pounded on my door and asked me to come with him; his newborn baby had been crying incessantly and nothing he and his wife had done could quiet the infant. I saddled my horse, put my new medicine bags across the saddle, and rode with him to his farm. The baby

acted as if he were in pain, but when I examined him I could find nothing wrong. I gave him a dose of Dover's Powders, an old formula containing narcotics which has probably been lost. The baby soon stopped crying; it also stopped breathing and turned blue. Frightened, I started artificial respiration, and after an interminable time the child began breathing and resting normally again. The overdose of narcotics and my good fortune in reviving the patient established my reputation as being a good baby doctor even though this was my very first call.

DR. L. E. PETTY, Borger.
(Deceased May 30, 1955)

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Galveston, April 21-25, 1956. Dr. J. Layton Cochran, San Antonio, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Executive Secy.

American Medical Association, Clinical Meeting, Boston, Nov. 29-Dec. 2, 1955. Dr. Elmer Hess, Erie, Pa., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, St. Louis, Feb. 6-8, 1956. Dr. Stanley F. Hampton, St. Louis, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 3-8, 1955. Dr. Arthur C. Curtis, Ann Arbor, Pres.; Dr. James R. Webster, 55 E. Washington St., Chicago 2, Secy.

American Academy of General Practice. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 13, 1955. Dr. William F. Mengert, Dallas, Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 9-14, 1955. Dr. Algernon B. Reese, New York, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 3-6, 1955. Dr. A. Crawford Bost, San Francisco, Calif., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery. Dr. Edward S. Welles, Saranac Lake, N. Y., Pres.; Dr. Paul C. Samson, 3959 Happy Valley Rd., Lafayette, Calif., Secy.

American Association of Genito-Urinary Surgeons. Dr. Fletcher H. Colby, Boston, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 8-10, 1955. Dr. Thaddeus L. Montgomery, Philadelphia, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 401 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Chicago, June 7-10, 1956. Dr. James H. Stygall, Indianapolis, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Los Angeles, April 16-20, 1956. Dr. George F. Strong, Vancouver 1, B. C., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 10-11, 1956. Dr. Warren W. Furey, Chicago, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Chicago, Oct. 31-Nov. 4, 1955. Dr. Alfred Blalock, Baltimore, Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Detroit, Aug. 28-Sept. 2, 1955. Dr. William D. Paul, Iowa City, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association. Dr. V. Pardo-Castello, Havana, Cuba, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association. Dr. Dwight L. Wilbur, San Francisco, Pres.; Dr. H. Marvin Pollard, University Hospital, Ann Arbor, Mich., Secy.

American Gynecological Society. Dr. Philip F. Williams, Philadelphia, Pres.; Dr John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, New Orleans, Oct. 22-26, 1955. Dr. E. Cowles Andrus, Baltimore, Pres.; Mr. Irving Hexter, 44 E. 23rd St., New York 10, Secy.

American Hospital Association, Atlantic City, N. J., Sept. 19-22, 1955. Dr. Frank R. Bradley, St. Louis, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Montreal, Canada, May 14-16, 1956. Dr. Dean M. Lierle, Iowa City, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association. Dr. Percival Bailey, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society. Dr. Everett L. Goar, Houston, Tex., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association. Dr. J. Warren White, Honolulu, Hawaii, Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society. Dr. Alfred H. Washburn, Denver, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society. Dr. A. W. Martin Marino, Brooklyn, N. Y., Pres.; Dr. Karl Zimmerman, 3500 Fifth Ave., Pittsburgh 13, Secy.

American Psychiatric Association. Dr. Alfred P. Noyes, Norristown, Pa., Pres.; Dr. William Malamud, 80 E. Concord St., Boston 18, Secy.

American Public Health Association, Kansas City, Mo., Nov. 14-18, 1955. Dr. Herman E. Hilleboe, Albany, N. Y., Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Boston, Oct. 29-Nov. 3, 1955. Dr. B. B. Sankey, Cleveland, Ohio, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association. Dr. John H. Gibbon, Jr., Philadelphia, Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Boston, May 28-31, 1956. Dr. George C. Prather, Brookline, Mass., Pres.; Dr. Samuel L. Raines, 188 S. Bellevue Blvd., Memphis, Tenn., Secy.

Association of American Physicians and Surgeons, Interim Meeting, Chicago, Oct. 7-8. Dr. James L. Doenges, Anderson, Ind., Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1955. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association. Dr. John H. Skavlem, Cincinnati, Pres.; Mrs. Morrell DeReign, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Chicago, Dec. 11-16, 1955. Dr. Tom B. Bond, Fort Worth, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, Houston, Texas, Nov. 14-17, 1955. Dr. Robert L. Sanders, Memphis, Tenn., Pres.; Mr. V. O. Foster, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hot Springs, Va., Dec. 6-8, 1955. Dr. Carrington Williams, Richmond, Va., Pres.; Dr. George Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, Sept. 21-22, 1955. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, Phoenix, Ariz., November, 1955. Dr. Joseph Bank, Phoenix, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Kansas City, Sept. 5-7, 1955. Dr. Lawrence P. Engel, Kansas City, Mo., Pres.; Dr. C. M. O'Leary, 207 Plaza Court Bldg., Oklahoma City, Secy.

Tri-State Medical Society, Texarkana, September, 1955. Dr. William B. Harrell, Texarkana, Pres.; Dr. Karlton Kemp, 408 Hazel, Texarkana, Ark., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas, Austin. Dr. Neil Buie, Marlin, Pres.; Mr. C. H. Rugeley, Wharton, Secy.

Texas Academy of General Practice, Fort Worth, Sept. 18-21, 1955. Dr. L. Bonham Jones, San Antonio, Pres.; Dr. Woodson W. Harris, 308 W. 15th St., Austin, Secy.

Texas Academy of Internal Medicine. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. W. A. Ostendorf, Fort Worth, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Houston, Dec. 8-10, 1955. Dr. Jarrett E. Williams, Abilene, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists. Dr. John Delany, Galveston, Pres.; Dr. Oran V. Prejean, 4317 Oak Lawn, Dallas, Secy.

Texas Chapter, American College of Chest Physicians, Galveston, 1956. Dr. Samuel Topperman, Tyler, Pres.; Dr. J. O. Armstrong, 3810 Swiss Ave., Dallas, Secy.

Texas Club of Internists. Dr. Charles Barrier, Fort Worth, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Houston, Nov. 14-17, 1955. Dr. E. B. Ritchie, Galveston, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association. Dr. Mavis P. Kelsey, Houston, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas, Pres.; Mr. Curt W. Reimann, 1609 Colorado, Austin, Acting Executive Director.

Texas Geriatric Society. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V. Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association. Dr. Kleberg Eckhardt, Corpus Christi, Pres.; Mr. Edgar M. Brown, 404 Jesse H. Jones Library Bldg., Texas Medical Center, Houston 25, Executive Director.

Texas Hospital Association, Dallas, April 3-5, 1956. Mr. Boone Powell, Dallas, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association. Dr. Stephen Weisz, Dallas, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association. Dr. Paul Williams, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Galveston, October 21-22, 1955. Dr. M. C. Carlisle, Waco, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society, Galveston, February, 1956. Dr. John McGivney, Galveston, Pres. and Secy.

Texas Public Health Association, Fort Worth, Feb. 26-29, 1956. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Fort Worth, Jan. 20-21, 1956. Dr. Martin Schneider, Galveston, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association. Dr. A. O. Singleton, Jr., Galveston, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association, San Antonio, Dec. 9, 1955. Dr. Charles H. Cornwell, Marlin, Pres.; Dr. Warren W. Moorman, 901 W. Leuda, Fort Worth, Secy.

Texas Society for Mental Health, San Antonio, March 1-3, 1956. Dr. Abe Hauser, Houston, Pres.; Mr. John Lane, 2510 San Antonio, Austin, Acting Executive Secy.

Texas Society of Anesthesiologists. Dr. Joe B. Wood, Dallas, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists. Dr. W. T. Arnold, Houston, Pres.; Dr. O. P. Griffin, 1101 Medical Arts Building, Fort Worth, Secy.

Texas Society of Ophthalmology and Otolaryngology, Galveston, 1955. Dr. A. E. Jackson, Fort Worth, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists. Dr. C. B. Sanders, Houston, Pres.; Dr. M. H. Grossman, St. Paul Hospital, Dallas, Secy.

Texas Surgical Society, Houston, Oct. 3-4, 1955. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Midland, April 6-7, 1956. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 2406 Manor Rd., Austin, Executive Secy.

Texas Urological Society, Austin, February, 1956. Dr. A. J. Ashmore, Corpus Christi, Pres.; Dr. Rex Carter, 1709 San Antonio, Austin, Secy.

DISTRICT

First District Society. Dr. Delphin von Briesen, El Paso, Pres.; Dr. W. G. Morrow, Jr., First National Bldg., El Paso, Secy.

Second District Society, Odessa, April 19, 1956. Dr. T. W. Novak, Odessa, Pres.; Dr. Willis T. Carson, 506 North Allegheny, Odessa, Secy.

Third District Society. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, Brownwood, Oct. 20, 1955. Dr. James N. White, San Angelo, Pres.; Dr. Joe B. Stephens, Bangs, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 7-9, 1955. Dr. John J. Sloan, Corpus Christi, Pres.; Dr. E. Jackson Giles, Medical Center, Suite 42, Corpus Christi, Secy.

Seventh District Society. Dr. John R. Rainey, Jr., Austin, Pres.; Dr. Leslie C. Colwell, 1410 Brazos, Austin, Secy.

Eighth District Society, Galveston, Sept. 16, 1955. Dr. George E. Glover, Jr., Victoria, Pres.; Dr. York Lancaster, Port Lavaca, Secy.

Ninth District Society, Baytown. Dr. Joseph T. Dabney, Livingston, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Society, Nacogdoches, Fall, 1955. Dr. J. C. Klein, Lufkin, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Palestine, 1955. Dr. Porter Bailes, Tyler, Pres.; Dr. Hugh F. Rives, Jacksonville, Secy.

Twelfth District Society, Temple, July, 1955. Dr. Neil Buie, Marlin, Pres.; Dr. J. H. Johnson, 304 South 22nd, Temple, Secy.

Thirteenth District Society. Dr. P. M. Kuykendall, Ranger, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. David Thomas, Denton, Pres.

Fifteenth District Society, Marshall, 1956. Dr. James Harris, Marshall, Pres.; Dr. L. E. Rutledge, Daingerfield, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 12-14, 1956. Dr. Alvin Baldwin, Jr., Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco, 1956. Dr. James T. Archer, Meridian, Pres.; Dr. Milton Spark, 121 Dallas St., Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, Feb. 27-March 1, 1956. Dr. Donovan C. Browne, New Orleans, Pres.; Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 17, 1955. Dr. E. C. Bebb, Broad St., Wichita Falls, Chm.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 24-27, 1955. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, Houston, July 18-20, 1955. Dr. C. Forrest Jorns, 5644 Lawndale, Houston, Secy.

State Tumor Conference, Wichita Falls, April 4, 1956. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

El Paso Doctors Create Loan Funds

An educational trust fund has been created by the El Paso County Medical Society to provide financial assistance to needy and qualified medical students. Any medical student from El Paso County who is attending any accredited medical school in the United States is eligible to apply for a loan. Selection of students for aid will be determined by the individual's financial need and potential or demonstrated ability and will be made regardless of race, color, creed, or sex. The fund is supported by annual assessments of members of the El Paso County Medical Society. Applications may be made to the society's education committee, which is composed of Dr. M. P. Spearman, Dr. Louis W. Breck, and Dr. Russell L. Deter, all of El Paso.

SOUTHERN MEDICAL ASSOCIATION

A Housing Bureau has been established for the convenience of out-of-town guests in making hotel reservations for the Southern Medical Association's forthcoming meeting in Houston November 14-17. Reservation blanks may be found in the June issue of the *Southern Medical Journal*. All requests must be cleared through the Housing Bureau, and since requests will be handled in chronological order, early applicants will receive first consideration. Requests for rooms should include the approximate dates and hours of arrival and departure and the names and addresses of all persons who will occupy the accommodations. All inquiries should be addressed to the Housing Bureau, Southern Medical Association, P. O. Box 1267, Houston.

NATIONAL AND STATE HEALTH LEGISLATION

The Texas Legislature recently completed its session and left in its wake three items of special interest to the medical profession. On the positive side, two bills were passed. The Texas Medical Association's major effort involved the securing of competitive rates on professional liability or so-called malpractice insurance.

This legislation restores competition among insurance companies which write professional liability policies. In the past, professional liability insurance was governed by the single rating law in this state. All companies were forced to charge the same, regardless of their experience rating. Last year one company which writes 70 per cent of the business in the state was forced to increase its rates an average of 50 per cent along with all other companies, even though it had publicly testified that an increase in rates was unjustified.

Favorable legislation also was enacted which will eliminate some of the paper work between the physician and the pharmacist. In the past, the doctor has been compelled to sign oral prescriptions for barbiturates within a period of 72 hours. This 72-hour clause has been eliminated. The druggist now can take prescription by telephone, make a record of the call, and then file it without the signature of the doctor. In addition to barbiturates, the physician will be permitted to give oral prescriptions for some narcotics.

The medical profession of Texas also was successful in its efforts to defeat a bill proposed by the naturopaths to expand their practice considerably. This legislation, if successful, would have completely legalized the practice of naturopathy. (It should be noted that the law licensing naturopaths previously had been held unconstitutional by the Attorney General of Texas.) Naturopaths would have been allowed to perform some types of surgery and to sign birth and death certificates.

Legislation pending in Washington provides basis for definite concern. The eighty-fourth session of Congress now is entering the "home stretch," and developments during the next few weeks will be of definite interest to the medical profession. Pertinent health bills are summarized hereafter.

Doctor Draft Law.—The Doctor Draft Law, due to expire on June 30, 1955, has been extended for two years. This legislation was opposed by both the Texas Medical Association and the American Medical Association on the basis of several considerations.

Most importantly, the drafting of doctors is believed to be unnecessary, except during time of war or national emergency. It is discriminatory legislation against the medical and dental professions since no other group is subject to a special draft. Organized medicine has taken the stand that doctors should be subject to the regular draft—just like all other Americans.

The Armed Forces presently have a much more favorable doctor-patient ratio than almost all areas of the country, including Texas. Also, the Defense Department has done little to attract and retain permanent medical personnel, and as long as it can freely draft doctors, the career appeal of military medicine will not improve.

Although the bill passed, one favorable amendment lowering the doctor draft age ceiling from 51 to 46 years was added. It also exempts physicians 35 years or older who at any time had applied for a commission and had been rejected on grounds of physical disability.

Salk Vaccine Legislation.—Numerous bills have been introduced which pertain to the distribution of the Salk poliomyelitis vaccine as well as the purchase of vaccine by the federal government. With the vaccine controversy now subsiding, chances are growing less that Congress will enact legislation to regulate distribution. Nevertheless, some type of legislation involving the purchase of vaccine by the government seems likely to be passed.

It seems quite possible that the House of Representatives will pass the Priest bill (H. R. 7126). This legislation provides (1) a grant to states taking into account 25 per cent of the number of unvaccinated eligible persons, the vaccine's cost, and the state's relative per capita income; (2) matching grants for additional vaccine to be used by public or nonprofit organizations; and (3) additional varying grants to cover administrative costs of public agencies. This bill leaves the states free to select methods of inoculations, and to decide what groups among the eligible (under 20 years, expectant mothers) are to receive special consideration.

Federal Health Reinsurance.—This legislation has remained completely dormant in the present session of Congress, along with other proposals which are a part of the Eisenhower health program. However, because federal health reinsurance (H. R. 3458 and S. 886) has the blessing of the administration, it seems possible that it may be pushed again next year.

Military Dependents.—A plan for a broadened and uniform application of medical care for dependents of all servicemen presently is under consideration. Although this proposal ranks high on the administration's priority list, definite action probably will await the next session of Congress.

Mental Health Survey.—Identical bills (H. J. R. 256 and S. J. R. 46) have been introduced authorizing federal grants totaling $1,250,000 to nongovernment groups for financing an extensive three-year survey of national health problems. The House of Representatives already has passed this bill, while the Senate Labor and Public Welfare Committee has held hearings on a companion bill with prospects that it will be reported favorably. This legislation is supported by the AMA. It has little opposition, and there is ample time for its enactment.

Federal Aid to Medical Education.—Bills which would provide federal financial assistance to medical schools have been introduced in both houses of Congress. This legislation would make grants-in-aid available to medical schools over a five-year period to stimulate new construction and expansion of facilities. Although the AMA has noted inherent dangers in federal subsidy, it favors this proposal on a one-time basis only. This legislation also has the uniform backing of medical schools. There appears to be considerable sentiment for this legislation, but time is running out and it may not be enacted.

Social Security.—Changes in the social security program seem imminent. Republicans and Democrats alike have proposed amendments. Proposals which are of vital concern to physicians include the paying of cash disability benefits to persons totally disabled who have social security coverage and the compulsory inclusion of physicians under the program.

Physicians who have studied this legislation fear that the payment of cash disability benefits represents the most serious threat to medicine in this Congress. They point out that it is a part of a plan drafted by the International Labor Or-

ganization for the socialization of medicine in this country.

A year ago, the eighty-third Congress passed social security legislation which identified the permanently and totally disabled. Now, the House Committee on Ways and Means has voted to pay cash benefits to those who are disabled. These persons would not be compelled to wait for retirement benefits until age 65 but could start collecting upon reaching age 50. This would require medical certification by physicians paid by the federal government. The next step most logically would be medical care for those who are disabled. This service would be provided by doctors receiving their remuneration from the federal government. In time, the program might be broadened to include others than those who are disabled.

This is the reason the Texas Medical Association is opposed to this proposal. Dr. J. B. Copeland of San Antonio, chairman of the Council on Medical Jurisprudence, has pointed out that paying of these cash benefits will result in increased regimentation of the medical profession and will lead inevitably to state medicine.

Though efforts continue to force physicians to participate in social security on a compulsory basis, this feature is not included in H. R. 7225, which presently is pending before the House of Representatives. The Texas Medical Association has gone on record in opposition to the compulsory inclusion of doctors in this act.

Jenkins-Keogh Bills.—As an alternative to inclusion under social security, the medical profession is supporting the Jenkins-Keogh bills in Congress. This legislation would establish a voluntary pension system for self-employed persons. If this legislation were enacted, doctors and other professional groups would be authorized to establish tax-deferred funds. Doctors could set aside up to 10 per cent of their net income up to $7,500 a year. The maximum for an individual would be $150,000 during a working life. Taxes would be deferred on this investment until income was received from it after retirement.

PERSONALS

Dr. Truman G. Blocker, Jr., Galveston, was elected president of the American Association of Plastic Surgeons at its April meeting.

Dr. Robert B. Morrison, Austin, and *Dr. John S. Chapman,* Dallas, were elected governor and regent, respectively, of the American College of Chest Physicians for Texas at the College's recent meeting in Atlantic City.

Dr. Titus H. Harris, Galveston, is the new auditor of the American Psychiatric Association.

Dr. Howard O. Smith, Marlin, was chairman of a scientific meeting of 200 physicians held June 1 in Chicago in connection with the convention of Rotary International.

Dr. William O. Russell, Houston, received one of the 21 research grants given early in May by the Tobacco Industry Research Committee.

Drs. Howard C. Coggeshall and *Donald W. Seldin,* both of Dallas, were speakers early in June at an international symposium in New York on the two new arthritis drugs, Meticorten and Meticortelone.

Dr. James M. Skelton, Mineola, has been accepted as a diplomate of the American Board of Internal Medicine.

Dr. Vernon L. Tuck, Sherman, is a new member of the board of directors of the Physician's Life and Accident Insurance Company of America.

SOUTHWEST CANCER CONFERENCE

The Southwest Regional Cancer Conference will be held in Fort Worth September 21-22. Guest speakers will be Dr. Edgar L. Frazell, surgeon, head and neck service, Memorial Hospital, New York; Dr. John R. McDonald, surgical pathologist, Mayo Clinic, Rochester, Minn.; and Dr. L. L. Robbins, radiologist, Massachusetts General Hospital, Boston. Dr. John J. Andujar, Fort Worth, will be moderator of a panel discussion on tumor case studies. There will be a question and answer period for the audience.

Interested physicians are invited.

LIBRARY SECTION

MEDICAL JOURNALISM IN TEXAS

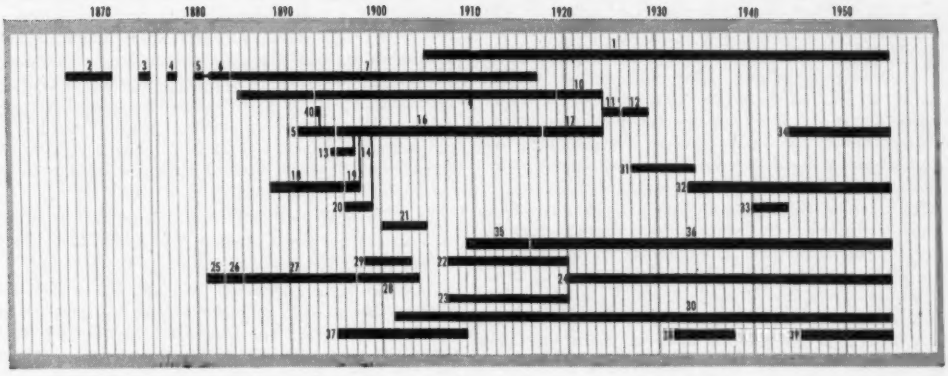
The sand of time on which the footprints of men of medicine are inscribed is not the sand of the age of dinosaurs; instead, it is the printer's ink of the journals and the books of their day. As in the search for dinosaur remains, the task is not so much a problem of reading the record as it is of finding the tracks which are hidden in the debris of time. The problem of medical history in Texas lies in the dearth of available information.

Whatever the quality of medical journals may be, it seems clear that the standards of medical practice have moved forward as medical journals have developed. When the physician transmits his thought processes to the printed page, he subjects his ideas to analysis and appraisal and to the criticism of his fellows. To survive this process he must, of necessity, survey his own position in detail and must organize his material to meet attack, thereby inevitably sharpening his own perception and abilities. The rapid progress of medicine seems almost directly related to the opportunities for publication of work that may exist.

The history of medical journals in Texas is an intricate pattern of success and failure. Dr. P. I. Nixon has smoothed the road for those interested in the history of Texas medicine; his work is invaluable to the beginner in this field and is a tribute to the industry of its author. The Board of Trustees of the Texas Medical Association has supported the collection of historical material and creditable progress is being made. This report is intended to provide a few more details about the history of journals.

The first mention of a medical journal in Texas occurred in 1840, just 43 years after the first medical journal in America, the *Medical Repository* of New York, was founded. There is no record, however, that this journal became any more than an idea. This mention of a journal appears in newspapers as follows: "Doct's Richardson and Smith propose to edit a Medical and Surgical Journal to be published in the offices of the San Luis Advocate, of the city of San Luis. The first number will appear in January next . . . to be published quarterly and contain about 64 pages." There is editorial comment that Dr. Smith was the author in 1832,

MEDICAL JOURNALS IN TEXAS



1. Texas State Journal of Medicine
2. Galveston Medical Journal
3. Texas Medical Journal
4. Galveston & Texas Medical Journal
5. Galveston Medical Journal
6. Texas Medical & Surgical Record
7. Texas Courier Record of Medicine
8. Daniel's Texas Medical Journal
9. Texas Medical Journal
10. Practical Medicine & Surgery
11. Pract. Med. & Surg. combining Med. Ins. & Health Cons.
12. Medical Insurance
13. Hygeia
14. Southwestern Medical & Surgical Reporter
15. Texas Sanitarian
16. Texas Medical News
17. Medical Insurance & Health Conservation
18. Texas Health Journal
19. Texas Medical Practitioner
20. Southwestern Medical Record
21. Texas Medical Gazette
22. Medical Annals of Southwest Texas
23. South Texas Medical Record
24. Medical Record & Annals
25. Texas Homeopathic Pellet
26. Southern Homeopathic Pellet
27. Southern Journal of Homeopathy
28. American Medical Monthly
29. Texas Clinics
30. Dallas Medical Journal
31. Harris County Medical Bulletin
32. Tarrant County Medical Bulletin
33. Travis County Medical Journal
34. Bulletin Potter County Medical Society
35. El Paso County Medical Society Bulletin
36. Southwestern Medicine
37. University Medical
38. Bulletin John Sealy Hosp. & School of Medicine
39. Texas Reports of Biology & Medicine
40. Southern Medical Review

in Paris, of a work on cholera spasmodica. From this we infer that Ashbel Smith was the "Doct. Smith" referred to in the notice.

Three Great Dynasties

There were in the early days of Texas three great dynasties of medical journals, each journal's life seeming to be limited more or less to that of the patriarch of the dynasty. The first of these arose in Galveston with Dr. Greensville Dowell as the sire and, it must be confessed also, the author of a large proportion of the material published. From 1866 for 14 years the fortunes of this publication were fraught with stubborn problems, none more thorny than the shortage of funds. This was probably the most expensive journal published in Texas insofar as subscribers were concerned, for the subscription was set at $5 per year. Advertising was very meager, and this journal, in the scraps that have been found, gave its principal attention to articles on fevers and to case reports. At various stages this pioneer appeared in many guises, first as the *Galveston Medical Journal* appearing at irregular intervals from 1866 to 1871, as the *Texas Medical Journal* and the *Galveston Texas Medical Journal* in the 1870's, again as the *Galveston Medical Journal* in 1880. At this point the flame that Dowell had fanned for 14 years threatened to spring into life as negotiations were in process to publish papers from the Texas State Medical Association as its official organ, but the death of Dowell apparently ended this.

In an effort to carry on the tradition Drs. J. F. Y. Paine and T. J. Heard, its associate editors, were linked with Drs. R. H. L. Bibb of Austin, F. Herff of San Antonio, C. H. Wilkinson of Galveston, E. J. Beall of Fort Worth, John H. Pope of Marshall, and D. Eagan of Sherman in the Texas Medical Publishing Company, which raised the *Texas Medical and Surgical Record* as the fifth generation of this clan. This was adopted as the official organ of the Texas State Medical Association, and with a part of the dues and the publication of the *Proceedings*, success seemed assured. Nevertheless, in three years the venture ended and was carried forward at Fort Worth under new management and without official blessing as the *Texas Courier Record of Medicine* that lived until 1917.

As in many royal families close relationships often existed and intermarriage occurred. Drs. F. E. Daniel and W. B. Brooks picked up the mantle of the *Texas Medical and Surgical Record* and founded the *Texas Courier Record of Medicine* in Fort Worth, but Dr. Daniel broke away in 1885 to found his own dynasty in Austin. The first of this order was *Daniel's Texas Medical Journal*, or the famous old "Redback." Printer's ink was in Daniel's blood, but he wrote in fiery style, and while in all things he was independent, he found it expedient to change the title to the *Texas Medical Journal* in 1893. Again, a new name came as confusion arose with the *Texas State Journal of Medicine* founded in 1905 by the State Medical Association of Texas. This new journal wore the banner *Practical Medicine and Surgery* from 1920 to 1924 with Dr. Daniel as founder and his wife, Mrs. Josephine Daniel, as managing editor and publisher. In 1923 a marriage occurred with the third dynasty resulting in the title, *Practical Medicine and Surgery*, combined with *Medical Insurance and Health Conservation*. In 1925 the title changed to *Medical Insurance* with Dr. S. A. Woolsey as editor, but Mrs. Daniel continued as managing editor and publisher. In October, 1929, Mrs. Daniel sold the journal to Dr. George L. Servoss, who moved the offices to Reno, Nev.

The third dynasty features the name of Dr. Matthew M. Smith of Austin and Dallas. The direct lineage begins with

the *Texas Sanitarian* of Austin, founded in 1891 by Drs. T. J. Bennett, R. M. Swearingen, J. W. McLaughlin, and T. D. Wooten. After four years during which the *Southern Medical Review* edited by N. J. Phenix of Houston was absorbed after only a single issue in June, 1894, this became the *Texas Medical News* with Drs. J. W. McLaughlin and T. J. Bennett as editors. They soon yielded to Dr. Matthew M. Smith, and the process of amalgamation began. In Tyler, a journal called *Hygeia* lived a short existence of four or five months in 1895 and was blended into the *Southwestern Medical and Surgical Reporter* of Fort Worth. The latter was assimilated by the *Texas Medical News* in 1897. The *Southwestern Medical Record* of Houston after three years of jousting with *Daniel's Texas Medical Journal* succumbed to the expansive mood of the *Texas Medical News* in 1899. In Dallas, the *Texas Health Journal* lived luridly for nine years, edited by J. R. Briggs, and carried forward under a new editor as the *Texas Medical Practitioner* devoted to general practice for a year, then was likewise engulfed by the *News* in 1897. The *Texas Medical News* lived for over 20 years and changed its name to *Medical Insurance and Health Conservation* in 1916 when Smith obtained the sponsorship of the Medical Sections of the American Life Convention and The National Fraternal Congress of America with 20 associate editors all over the nation. As Smith's health failed, Mrs. Daniel became managing editor and publisher, returning the periodical to Austin, the place of birth of the dynasty and bringing the final change of title to *Medical Insurance.*

Other Periodicals

Other journals, not related to the royal families, have also appeared. The *Texas Medical Gazette* of Fort Worth expired at age 5 in 1905, apparently stepping aside for the society journal. In San Antonio, the *Bexar County Bulletin* developed into the *Medical Annals of Southwest Texas* but lost its identity when it was merged with the *South Texas Medical Record* to form *Medical Record and Annals* under the business managership of Thomas M. Darlington, who later moved the offices to Houston, where this journal became the official organ for the Harris County Medical Society, the South Texas District Medical Society, the Postgraduate Medical Assembly of South Texas, and the Texas Association of Obstetricians and Gynecologists. With this support, this journal has survived and has consistently presented a good format with well organized material, although its scope has been regional. From the Medical Branch of the University of Texas at Galveston, various publications have developed. The *University Medical* from 1895 for 14 years, the *Bulletin of John Sealy Hospital and School of Medicine* in the 1930's, and *Texas Reports on Biology and Medicine* from 1945 to date are the journals recorded in this study.

The *Dallas Medical Journal* began service in 1901 and is now in its forty-first volume, a neat, small, local journal. Harris County Medical Society published a *Bulletin* from 1927 to 1934. The *El Paso County Medical Society Bulletin* was published from 1909 to 1916 until its merger with the *Arizona Medical Journal* to form *Southwestern Medicine.* The *Tarrant County Medical Society Bulletin* was established in 1933 and still is fully alive. The *Travis County Medical Journal* persisted for four years from 1940 to 1943. A more recent addition is the *Bulletin of the Potter County Medical Society.* The *Texas Clinics* of Dallas lasted a short time under editorship of Dr. J. B. Shelmire, and the *Medical Bulletin,* represented by a single copy in the Southwestern Medical School Library, was published by the Dallas County Medical Society in the 1920's with Dr. J. M. Martin as editor in chief for an uncertain length of time.

The *Homeopathic Pellet* is represented at Barker History Center at the University of Texas by only a scrap from 1883. It originated in Austin with C. E. Fisher as editor apparently in 1881; after two volumes the name changed to *Southern Homeopathic Pellet* for two more volumes. From 1885 until 1897 the journal was designated *Southern Journal of Homeopathy,* a monthly journal of medical science and art described as well edited. During this period the journal was moved to New Orleans and became the *American Medical Monthly* until 1904.

The history of the TEXAS STATE JOURNAL OF MEDICINE, the organ of the Texas Medical Association, is another story.

To the reader of modern medical literature these older journals in some aspects are woefully inadequate, but the editorial pages tend to make present publications appear pale by comparison. The appelations of liar, thief, mountebank, and pretender and similar lurid terms are commonplace in the journalism of that day. Withal there is a sense of intimacy and homeliness that might be copied with advantage. For sheer fury one may refer to the Daniel-Briggs debates in the *Texas Health Journal* and the *Texas Medical Journal;* for humor one may turn to Daniel's report on Dorset's hurling of the spittoon at the nurse's head at the State Lunatic Asylum; for excellent reasoning McLaughlin's series of articles on infection and immunity in the *Texas Sanitarian* is worthy of mention; for succinct factual reporting there is *Texas Medical News.* The *Texas Courier Record of Medicine* featured condensations of medical articles with a format similar to *Reader's Digest* in its early years.

Appreciation is expressed for aid and comments offered by Miss Pauline Duffield, librarian of the Texas Medical Association; Dr. Llerena Friend and Mrs. Marcelle Hamer of the Barker History Center at the University of Texas in Austin; Dr. S. V. Connor of the Texas State Archives; and Mrs. Violet M. Baird, librarian of Southwestern Medical School of the University of Texas in Dallas.

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1. Nixon, P. I.: Century of Medicine in San Antonio; Story of Medicine in Bexar County, Texas, San Antonio, published by the author, 1936.

2. Nixon, P. I.: History of Texas Medical Association, 1853-1953, Austin, University of Texas Press, 1953.

3. San Luis Advocate, Oct. 20, 1840.

4. Files of medical journals listed, mostly incomplete, with the exception of Hygeia and Texas Medical Gazette, which so far have not been located.

J. M. COLEMAN, M. D., Austin, Texas.

108 West Thirtieth.

BOOKS RECEIVED IN JUNE

Benford, R. J.: Doctors in the Sky, Springfield, Ill., Charles C Thomas, 1955.

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Year Book of Endocrinology, Chicago, Year Book Publishers, 1954-1955.

CONTRIBUTIONS TO THE LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Anesthesiologists, Austin, 25 journals.

Dr. Josephine N. Dunlop, Austin, 44 journals.

Dr. J. E. Johnson, Austin, 27 journals, 8 reprints.

Dr. James E. Kreisle, Austin, 1 book.

Dr. W. D. Roberts, Austin, 116 journals.

Dr. Rene Naccahe, Beyrouth, Lebanon, 1 book.

Dr. Nelson L. Schiller, Austin, 14 journals, 3 reprints.

Dr. Oliver W. Suehs, Austin, 169 journals.

Dr. David R. Womack, Austin, 19 journals.

MOTION PICTURES FOR LOAN

Stop Rheumatic Fever

16 mm., black and white, animated, sound, 12½ minutes. Cleared for television in 1954. Prepared by the National Heart Institute, United States Public Health Service, Department of Health, Education, and Welfare, in cooperation with the Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association. (Property of the Texas Medical Association Memorial Library.)

In this film rheumatic fever is represented by an animated smoky flame, which sometimes flares up and sometimes lies almost dormant, an action which is characteristic of the disease. The streptococcal infection is symbolized as the forerunner of rheumatic fever. The film shows that rheumatic fever can be prevented by prompt and thorough treatment of streptococcal infections and that with the combined efforts of parents, teachers, nurses, social workers, and physicians, rheumatic fever and streptococcal infection can be successfully overcome. This film is fine for showing to all adult groups.

Enzyme Therapy with Varidase

16 mm., sound, color, 18 minutes. Prepared by W. H. Lutz, M. D., and M. B. Donaldson, M. D., 1952. (Courtesy of Lederle Laboratories.)

The film presents a brief history of Aureomycin and demonstrates its gross clinical effect on diseases representing the major groups of infections. The infections include those due to bacterial, rickettsial, virus-like, protozoan, and spirochetal organisms. It is of interest to all medical groups.

BOOK NOTICES

[1]Vaginal Hysterectomy

LAMAN A. GRAY, A. B., M. D., F.A.C.S., *Associate Professor, Obstetrics and Gynecology, University of Louisville School of Medicine, Louisville, Ky. 137 pages. $4.75. Springfield, Ill., Charles C Thomas, 1955.*

This small book is excellent. I would heartily recommend it to all interested groups. The section on the history of the operation, including the preoperative preparation, the technical application, and postoperative care, is especially good. The discussions are clear, presented in a helpful manner.

The only criticism of this book is that it needs more plates and diagrams. Those that are included are very good.

[2]Neck Dissections

JAMES BARRETT BROWN, M. D., *Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Mo., and Chief Consultant in Plastic Surgery, United States Veterans Administration, Washington, D. C., and* FRANK MCDOWELL, M. D., *Assistant Professor of Clinical Surgery, Washington University School of Medicine, St. Louis. 163 pages. $7.50. Springfield, Ill., Charles C Thomas, 1954.*

This is an excellent book about carcinoma of the head and neck, both from the clinical and surgical aspects. It is well illustrated and contains colored plates of the radical neck operation as done by the author. This discussion on treatment is well done with good results reported by the author.

[3]The Human Brain in Sagittal Section

MARCUS SINGER, PH. D., *Professor of Zoology, Cornell University, and* PAUL I. YAKOVLEV, M. D., *Assistant Clinical Professor, Department of Neurology, Harvard Medical School. 81 pages. $7.75. Springfield, Ill., Charles C Thomas, 1954.*

This study is a departure from the traditional study of the brain by frontal and horizontal sections of the cerebral hemispheres and the transverse sections of the brain stem and spinal cord to which most of us have been exposed.

This work is a refreshingly different approach to the subject and from the first one has the problem of orienting oneself in a new procedure of identification of structures. One's problem might have been somewhat lessened had different colors been used for the different nuclei, for different tracts and their fibers and as differential viewing of the grey and white matter, as well as the ventricles.

Perhaps this is the lazy man's way of approach but one cannot help but feel that the instructional value of this monumental piece of work would have been immeasurably enhanced by the simple addition of color, but the cost would probably have been prohibitive.

One would like to commend this work for the use of Basel Nomina Anatomica terminology as it allows much wider distribution of this very instructive monograph. This work one feels is best suited for libraries, neurologists, neurosurgeons, or those interested in the anatomy of the brain. It might also be of interest to psychiatrists as an anatomical reference work. This work, of course, will find its greatest usage in the departments of anatomy of our medical schools.

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[1]*C. G. Goddard, M. D., Bastrop.*

[2]*Mitchell S. Madison, M. D., Austin.*

[3]*Joe C. Rude, M. D., Austin.*

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

TEXANS ACTIVE AT AMA MEETING

Texas delegates to the House of Delegates of the American Medical Association played an important role in the deliberations of that body at its meeting in Atlantic City, N. J., on June 6-10, and Dr. F. J. L. Blasingame of Wharton, immediate past president of the Texas Medical Association, received new recognition from the Board of Trustees of the American Medical Association.

He was appointed vice-chairman of the Board of Trustees, and also will serve as chairman of the Board's Executive Committee.

Mr. C. Lincoln Williston, Executive Secretary of the State Association, served as secretary of the Section for Large State Medical Associations at the ninth annual Medical Society Executives Conference.

Ten of the seventy-three resolutions considered by the House of Delegates were presented by representatives from Texas. These included six which were adopted by the House of Delegates of the Texas Medical Association at Fort Worth earlier this year.

For the first time Texas was represented by seven delegates in contrast to six in recent years. The seventh Texas delegate, Dr. James H. Wooten of Columbus, was seated in view of the state's increased membership in the American Medical Association. Texas physicians holding AMA membership totaled 6,060 during the past year. One delegate is recognized for each 1,000 membership, plus one for the remaining fraction.

Dr. Milford O. Rouse, Dallas, served as head of the Texas delegation for the Atlantic City meetings. Other delegates who participated were Dr. J. B. Copeland, San Antonio; Dr. John K. Glen, Houston; Dr. L. C. Heare, Port Arthur; Dr. A. C. Scott, Temple; and Dr. T. C. Terrell, Fort Worth.

Two Texas physicians were appointed to councils of the AMA by the House of Delegates. Dr. B. E. Pickett, Sr., Carrizo Springs, was re-elected to serve a five-year term on the Council on Constitution and By-Laws, and Dr. A. C. Scott was elected to a similar term on the Council on Medical Service, after having completed serving an unexpired term of one year on that body.

Texas delegates held open house throughout the meeting in their hospitality suite at the Traymore Hotel. Official certificates issued by the Attorney General, authorizing individuals the right to brag about Texas, were issued to delegates from other states and to friends. Members of the Texas Medical Association also were welcomed in the hospitality suite.

The Texas delegation was particularly active in deliberations on the osteopathic issue, resulting from a report of the 1955 Committee for the Study of Relations Between Osteopathy and Medicine.

Dr. Milford O. Rouse of Dallas was appointed to serve as a member of the Reference Committee on Medical Education and Hospitals, which considered the report and heard voluminous testimony by many physicians. He presented the minority report, which advised that attempts to discuss the relations of osteopathy and medicine be discontinued until the "cultist" healing and "osteopathic concept" be abandoned by action of the House of Delegates of the American Osteopathic Association.

The majority report, in contrast, recommended that doctors of medicine be allowed to teach in colleges of osteopathy, that state medical associations assume the responsibility of determining the relationship of osteopathy and medicine, and that the Board of Trustees appoint a committee to confer with representatives of the American Osteopathic Association on interprofessional problems at the national level.

The minority report presented by Dr. Rouse was adopted by the House of Delegates.

Other business considered included a change in medical ethics regarding physicians' ownership of drug stores, internship programs, accreditation of hospitals, poliomyelitis vaccine, and various miscellaneous actions. A full report of the convention may be found in the *Journal of the American Medical Association.*

AMA PLANS PUBLIC RELATIONS INSTITUTE

The 1955 American Medical Association Public Relations Institute will be held August 31 and September 1 in Chicago. Discussions will be held on grass roots activity in national legislation, basic public relations techniques, medicine in the magazines, and the individual's role as a public relations communicator. Registrants will have an opportunity to exchange ideas with other public relations men on their projects and problems, and a session on forthcoming AMA public relations activities will be held.

All medical society officers and headquarters personnel, public relations committee chairmen, and Woman's Auxiliary personnel and officers are invited to the meeting.

COUNTY SOCIETIES

Bell County Society

June 1, 1955

(Reported by J. B. Brown, Secretary)

Cancer Control in Bell County—Charles Phillips, Temple.

The above scientific report was presented at the June 1 meeting of the Bell County Medical Society in Temple. Dr. Phillips also showed a film on lung cancer from the American Medical Association. R. A. Murray, delegate, gave a report on the recent annual session of the Texas Medical Association.

It was decided that a permanent Public School Health Committee was needed in Bell County since the superintendent of schools had asked the society to appoint a committee to help formulate some of the health practices of the public schools. Harry Frey was appointed chairman of the committee and two other members were to be appointed by the president.

Bexar County Society

April 19, 1955

Ureteral Injuries—C. G. Sutherland, Fayetteville, Ark.

The Bexar County Medical Society heard the above scientific program at its meeting in San Antonio on April 19.

Big Bend Counties Society

May 3, 1955

(Reported by D. J. Sibley, Jr., Secretary)

Renal Function in Health (motion picture).
Sciatica and the Ruptured Intervertebral Disk (motion picture).

Edwin P. Read, Iraan, sponsored the above scientific program, which followed a dinner on May 3 in Fort Stockton. The Big Bend Counties Medical Society also heard a letter regarding the Salk vaccine.

Cass-Marion Counties Society

May 11, 1955

Diseases of the Skin—R. P. Hughes, Texarkana.

The Cass-Marion Counties Medical Society met with the auxiliary on May 11 in Linden for a dinner. Afterwards, the doctors heard the above scientific program.

Colorado-Fayette Counties Society

April 20, 1955

Fractures in Children—G. W. N. Eggers, Galveston.

At the April 20 meeting of the Colorado-Fayette Counties Medical Society in Eagle Lake, Dr. Eggers, a Galveston surgeon, presented the scientific program.

Dallas County Society

April 12, 1955

(Reported by Glenn D. Carlson, Secretary)

Medical Treatment of Chronic Ulcerative Colitis—John S. Bagwell, Dallas.
Indications for, and Surgical Techniques Employed in Treatment of Chronic Ulcerative Colitis—Robert J. Rowe, Dallas.
Discussion—Cecil O. Patterson, Dallas.

At the April 12 meeting in Dallas of the Dallas County Medical Society, George V. Launey was elected vice-president; Murphy Bounds, delegate; and Milton Davis, alternate delegate, to fill existing vacancies. Fifteen new members were elected. The members voted to instruct their delegate to the annual session of the Texas Medical Association to vote for the removal of the word "white" from the section defining membership qualifications.

El Paso County Society

April 26, 1955

Treatment of Pulmonary Diseases (motion picture).

The April 26 meeting of the El Paso County Medical Society was held in El Paso, and the above film was shown.

Howard-Martin-Glasscock Counties Society

April 19, 1955

The Howard-Martin-Glasscock Counties Medical Society met on April 19 in Big Spring to make plans concerning inoculation with Salk vaccine, and to decide on a priority schedule.

Tarrant County Society

May 17, 1955

(Reported by S. W. Wilson, Secretary)

Panel Discussion: Carcinoma of the Breast—Jerry Miller and John Mallams, Dallas, and Vern Rohrer and Otto H. Grunow, Fort Worth.

The scientific program for the Tarrant County Medical Society's May 17 meeting was presented by the Fort Worth and Dallas Radiological Societies. A new amendment providing for two years of probationary membership was presented and was to be acted on at the next meeting. Members adopted a resolution protesting Senate Bill 1323, which provides for federal subsidy to medical schools.

Tierra Blanca Society

June 21, 1955

(Reported by B. A. Masters, Secretary)

Typhoid Meningitis in Newborn—Paul Spring, Friona.
Bacteriologic and Pathologic Aspects of Typhoid Fever—Thomas B. Smith, Friona.
Diagnosis and Treatment of Typhoid Fever—Floyd Lee Spring, Friona.

The Tierra Blanca Medical Society met in Hereford on June 21 and heard the above program on typhoid. The society went on record as opposing intervention by the federal government in the manufacture and distribution of Salk poliomyelitis vaccine.

AUXILIARY SECTION

THE AUXILIARY'S NEWS LETTER

The *News Letter* of the Woman's Auxiliary to the Texas Medical Association is now three years and one issue old, its first issue having been published in Fort Worth on April 20, 1952.

In that first issue, Mrs. O. W. Robinson, Paris, President of the Woman's Auxiliary at the time, stated: "The purpose of the *News Letter* is to promote public relations in its best form. It is a medium by which we will strive to keep the entire membership alerted to impending legislation as pertains to health and other phases of the medical profession. It will also be a means of conveying important announcements and added valuable information to individual members, even in remote sections of the state. It will tend to unify and solidify our large organization."

Mrs. C. P. Lipscomb, Fort Worth, edited the first issue, four pages devoted to the President's message, letters of congratulations and encouragement from various officials, the program for the thirty-fourth annual session, and several personal and news items.

The *News Letter* was well received by Auxiliary members, and Mrs. Robert F. Thompson of El Paso, President in 1952-1953, appointed Mrs. Haskell D. Hatfield, El Paso, to continue the publication as its second editor. Several conferences were held with Auxiliary and Association officials and staff, from which the general plan and policy of the *News Letter* were evolved.

It was decided that the *News Letter* would not depart radically from its first issue. It was to be financed from the Auxiliary's Special Fund; it was not to solicit advertising nor be financed from other than Auxiliary funds. It was to be published in the printing department at the central office in Austin and to be mailed from there.

After the first issue, the format of the publication was determined in part by the size of the Multilith machine on which it is printed, the page being 6¾ by 9¾ inches. Its

insignia, the Lone Star of Texas in outline around the profile of Hygeia's head, was altered to conform to the smaller page.

Four issues of the *News Letter* were published during its first year. Then Mrs. E. W. Coyle, San Antonio, President for 1953-1954, reappointed Mrs. Hatfield as editor and endorsed her request for a full-scale conference on Auxiliary publications. The conference was held during the fall Executive Board meeting with the Presidents and Presidents-Elects of both the Auxiliary and the Medical Association, representatives of the JOURNAL, the publicity secretary of the Auxiliary, and staff members of the central office being present. The job of the *News Letter* was defined and its place among the publications available to Auxiliary members clarified. It was agreed that the *News Letter* would not replace the Auxiliary pages in the JOURNAL, nor would it use material in duplication of that customarily published in the JOURNAL. It would not carry vital statistics or personal announcements but would serve as the medium through which the Auxiliary would speak to its members.

Since that time, in keeping with the policies suggested at the conference, the *News Letter* has carried stories and pictures relating to news of the Auxiliary, information, education, inspiration, and program activation. It stimulates interest in Auxiliary projects, reports state and national meetings, introduces the personnel of the Auxiliary to other members, translates state and national programs into news through the activity of officers and individuals, and is a constant channel of pertinent information on legislation, health education, and community service.

The plan of publication has been that six issues of four to eight pages each, designed to serve the Auxiliary calendar, will appear annually within a maximum budget of $2,000.

Correspondence from Past Presidents of the Auxiliary, national officers, and other state editors has indicated that the policies adopted in Texas in general are in keeping with policies of other news letters and with the best traditions of the Auxiliary.

Mrs. Hatfield continued to edit the *News Letter* during the administration of Mrs. Mark H. Latimer of Houston, President in 1954-1955. The *News Letter's* third editor, Mrs. F. Paul Burow, Killeen, recently took office under Mrs. Joseph H. McCracken, Jr., Dallas, the President for 1955-1956, and the publication continues as a major informational and promotional tool of the Auxiliary.

MRS. HASKELL D. HATFIELD, El Paso.

COUNTY AUXILIARIES

Members of the *Navarro County Auxiliary* heard detailed reports on the business meetings and social affairs held at the annual session at the auxiliary's May 6 meeting at the home of Mrs. Ben Griffin, Frost. At its June 3 meeting, Mrs. Louis Gibson, Corsicana, presented the program which consisted of a condensed report from "The Bulletin" on "Leadership in Community Health," an article by Mrs. George Turner, past president of the National Woman's Auxiliary.

Several auxiliaries have elected new officers. The *Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Auxiliary* on April 21 in Monahans elected Mrs. Fred J. Prout, president; Mrs. Paul Kunstadt, secretary; and Mrs. Otto Munk, treasurer. All are from Monahans. Mrs. Joshua Seidel was named president of the *Kerr-Kendall-Gillespie-Bandera Counties Auxiliary* at the meeting held May 6 at the home of Dr. and Mrs. W. E. Bell, Kerrville. Other officers, all of Kerrville, are Mrs. David McCullough, first vice-president; Mrs. D. E. Packard, second vice-president; Mrs. Luther Ross, third vice-president; Mrs. C. C. Jones, Jr., secretary; and Mrs. Hugh Drane, treasurer.

News officers were installed at the final meeting of the season of the *Bexar County Auxiliary* in San Antonio. Officers are Mrs. L. Bonham Jones, president; Mrs. Jack Partain, president-elect; Mrs. F. G. Lahourcade, first vice-president; Mrs. Alfred Nisbet, second vice-president; Mrs. M. A. Childers, Jr., third vice-president; Mrs. Everett T. Duncan, fourth vice-president; Mrs. Alvin Thaggard, Jr., recording secretary; Mrs. G. G. Passmore, corresponding secretary; and Mrs. Richard E. Nitschke, treasurer. The officers are from San Antonio.

Mrs. W. J. Woolsey, Waco, was hostess for the *McLennan County Auxiliary* at a coffee in her home on May 25. Officers for the next season were installed, and they are Mrs. Loyal K. Wilson, president; Mrs. L. D. Collins, first vice-president; Mrs. George Bryant, second vice-president; Mrs. C. F. Miller, third vice-president; Mrs. Charles Shellenberger, fourth vice-president; Mrs. James H. Scruggs, Jr., recording secretary; Mrs. W. J. Woolsey, corresponding secretary; and Mrs. Moreton Magid, treasurer. All the officers are from Waco.

May 25 was celebrated as Doctor's Day by members of the *Tom Green-Eight County Auxiliary*. They entertained their husbands with a dinner at the home of Dr. and Mrs. James N. White, San Angelo. A "king for a day" theme was used in the decorations. On May 11, the *Ellis County Auxiliary* honored members of the Ellis County Medical Society with a dinner at the Ennis Country Club.

At an informal barbecue at the home of Dr. and Mrs. L. C. Heare, Port Arthur, the *Jefferson County Auxiliary* honored doctors in that area in May. New officers of the auxiliary, all of Beaumont, are Mesdames J. C. Crager, president; Winston Cochran, first vice-president; M. E. Suehs, second vice-president; R. T. Lombardo, secretary; and Russell J. Catalano, treasurer.

At a recent meeting of the *Galveston County Auxiliary*, Mrs. M. A. Caravageli was installed as president of the group. The meeting was held at the home of Dr. and Mrs. Martin L. Towler, Galveston, and was combined with a garden party for auxiliary members. Newly elected officers are Mesdames Charles T. Stone, Jr., president-elect; Fred Wolma, vice-president; W. A. Wilson, treasurer; M. Lake Fowler, corresponding secretary; and W. T. Matlage, recording secretary.

At the April 29 meeting of the *Webb-Zapata-Jim Hogg Counties Auxiliary*, Mrs. Aubrey S. McGee was elected president. Officers elected to serve with her for 1955-1956 are Mrs. M. L. Fuller, first vice-president; Mrs. J. L. Crawford, second vice-president; Mrs. Francisco M. Canseco, secretary; Mrs. Juaquin Gonzalez Cigarroa, Jr., treasurer; Mrs. Albert C. King, corresponding secretary; and Mrs. Edward Grantham, parliamentarian. The meeting was at the home of Dr. and Mrs. G. M. Canales, Laredo, and plans were made for a May 2 luncheon at which the officers were to be installed.

Officers of the Woman's Auxiliary to Texas Medical Association: President, Mrs. Joseph H. McCracken, Jr., Dallas; President-Elect, Mrs. R. C. Bellamy, Liberty; First Vice-President, Mrs. Harold Lindley, Pecos; Second Vice-President, Mrs. William C. Barksdale, Borger; Third Vice-President, Mrs. Scott H. Martin, San Angelo; Fourth Vice-President, Mrs. L. L. D. Tuttle, Houston; Fifth Vice-President, Mrs. John C. Parsons, San Antonio; Treasurer, Mrs. J. C. Terrell, Stephenville; Recording Secretary, Mrs. Franklin Campbell, Fort Worth; Corresponding Secretary, Mrs. O. M. Marchman, Jr., Dallas; Publicity Secretary, Mrs. Joe Thorne Gilbert, Austin; Parliamentarian, Mrs. O. W. Robinson, Paris.

DEATHS

L. W. JOHNSTON

Dr. Lawrence Walton Johnston, vice-councilor and secretary of the Fourteenth District Medical Society, died in Falls Church, Va., on May 15, 1955, of a coronary occlusion. Dr. Johnston was a resident of Terrell, Texas, and was en route to Geneva, Switzerland, to attend a meeting of the International College of Surgeons. He had just completed a one-week postgraduate course at the University of Chicago.

DR. L. W. JOHNSTON

Dr. Johnston was born on April 5, 1910, in Fort Worth, and was the son of Charlotte (Walton) Johnston and C. W. Johnston, a dentist. He attended high school in Fort Worth, and received his bachelor of arts degree from Texas Agricultural and Mechanical College in 1930. He attended North Texas State Teachers College in 1932 and 1933 then entered Baylor University College of Medicine, from which he was graduated in 1938. Dr. Johnston was an extern in Parkland Hospital, Dallas, and the Dallas Medical and Surgical Hospital. He served his internship at the Shreveport Charity Hospital, Shreveport, La.

In 1939, Dr. Johnston helped to open the Holton-Johnston Clinic and Hospital in Terrell, where he was in active practice at the time of his death. He was in partnership with his father-in-law, Dr. R. W. Holton, who was recently named general practitioner of the year by the Texas Medical Association. In the clinic, Dr. Johnston was chief surgeon, a position which he also had held at the Terrell State Hospital for the past two years. He was a past president and secretary of the Kaufman County Medical Society, and a past president and vice-president of the Fourteenth District Medical Society, and was secretary-treasurer from 1949 until the time of his death. He also was a member of the Texas and American Medical Associations and was an officer for several years of the Texas Division of the American Cancer Society. He also was a member of the American Academy of General Practice and was an associate member of the Dallas Southern Clinical Society.

Dr. Johnston took an active part in Terrell's civic affairs; he had served as vice-president of the Chamber of Commerce for the past three years, was chairman of the group's industrial committee, and was a member of the health committee. In 1952, he formed a citizen's committee which worked for the successful passage of bonds for a new school. He had been currently planning a new bond drive for street, park, and city hall improvements. He also was a member of the Terrell Lions Club and was a director of the Terrell State Bank. He was a thirty-second degree Mason and a member of the Shrine and was a member of the Christian Church.

On August 12, 1937, Miss Marguerite Holton and Dr. Johnston were married in Terrell. Survivors include Mrs. Johnston; two daughters, Linda Lou, 15, and Carol Ann, 13; his mother, Mrs. C. W. Johnston, Fort Worth; and a sister, Mrs. John Achterberg, El Paso.

M. J. KUYKENDALL

Dr. Middleton J. Kuykendall died in Jacksonville, Texas, on March 28, 1955, of an acute coronary condition.

Dr. Kuykendall was born on March 8, 1884, in Beckville. His parents were James Marion and Lillie Rebecca (Shivers) Kuykendall. After attending public schools in Beckville, Dr. Kuykendall attended the Memphis Hospital Medical College, Memphis, Tenn., and was graduated in 1910. He spent his internship at St. Joseph's Hospital, Memphis. He practiced in Beckville and Longview from 1910 until 1925, then practiced 14 years in Bullard and 3 years in Wortham. In 1942 he moved to Rusk and was

DR. M. J. KUYKENDALL

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

a staff member of the Rusk State Hospital until he retired in February, 1955.

Dr. Kuykendall was a member of the Texas and American Medical Associations successively through the Panola, Polk-San Jacinto, Leon, Smith, Navarro, and Cherokee Counties Medical Societies.

Miss Clara Allison Donovan and Dr. Kuykendall were married in Carthage in 1910, and Mrs. Kuykendall died in May, 1940. Dr. Kuykendall married Mrs. Vivian Pryor Osborne in Rusk in 1942. She died in June, 1954.

Survivors include one son, Edwin D. Kuykendall, Dallas, and three sisters, Misses Gracie B. and Retta Kuykendall, Beckville, and Mrs. Roy Overstreet, Bowie.

L. E. PETTY

Dr. Lester Edwin Petty died at his home in Borger, Texas, on May 30, 1955, of an irreversible atrioventricular block, fibrosis-emphysema, and arteriosclerosis.

DR. LESTER E. PETTY

Dr. Petty was born to Berry and Lydia Jane (Morgan) Petty in Kentucky in 1873. He attended public schools in Lawrenceburg, Ky., and then was graduated from Kentucky University in 1900. Coming to Texas to begin his medical career, Dr. Petty practiced briefly in Leo, Rosston, Dye, and Mallard, then moved to Forestburg, where he remained for 20 years. After practicing for ten years in Panhandle and three years in Tyler, Dr. Petty settled in Borger in 1936 and was in active practice there until shortly before his death. He had been city health officer since 1933.

Having been a member of the Texas Medical Association almost continuously since 1904, Dr. Petty was elected to honorary membership in the Association in 1948. He had been a member of the Texas and American Medical Associations through the Montague, Potter, Hutchinson-Carson, and Top O'Texas Counties Medical Societies. He was a past president of the Hutchinson-Carson Counties Society and was a member of the Fifty Year Club.

In his community, Dr. Petty was a member of the Chamber of Commerce, the Lions Club, Rotary International, the Masonic Lodge, and the Baptist Church.

Miss Bessie Lee Jackson and Dr. Petty were married on October 13, 1901, in Forestburg, and five children were born to them. Survivors include his wife; four daughters, Mrs. K. W. Boylan, Mrs. C. M. Hitchcock, and Mrs. Willie Fay Ussery, of Borger, and Mrs. R. T. Terry, Denver; and one son, M. J. Petty, Benicia, Calif.

G. W. HINKLE

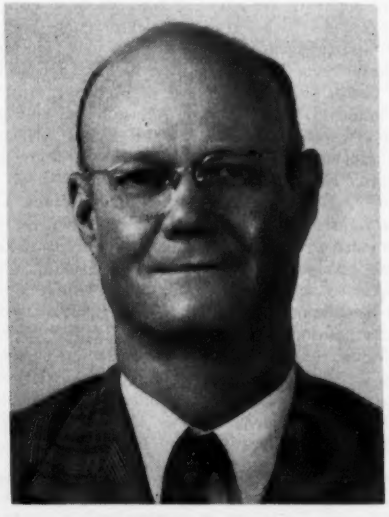
Dr. George William Hinkle, Denton, Texas, physician and surgeon, died of a coronary occlusion at his home on April 20, 1955. Only five days prior to his death, Dr. Hinkle and his wife had returned from a trip to Europe with the New Orleans Graduate Medical Assembly. He had attended medical meetings in Paris, Rome, Munich, Copenhagen, Stockholm, and London.

Dr. Hinkle was born to Mr. and Mrs. Will C. Hinkle in Red Oak on May 10, 1903. He attended Waxahachie High School, and was graduated from Trinity University, then in Waxahachie, in 1928. After receiving his doctor of medicine degree in 1934 from the University of Texas Medical Branch, Galveston, he interned in the Detroit Receiving Hospital for one year. The following year, he spent his residency in obstetrics and surgery at the Methodist Memorial Hospital, Fort Worth. Dr. Hinkle began his practice in Denton in 1936 and was practicing there at the time of his death.

A past president and secretary of the Denton County Medical Society, he also was a member of the Texas and American Medical Associations and the Fourteenth District Medical Society. He helped to found the Medical-Surgical Clinic in Denton in 1949 and was senior surgeon of the group. He also was active in the clinic maintained by Kiwanians for underprivileged children.

A sports enthusiast and former semiprofessional baseball player, Dr. Hinkle was active in organizing the Bronco Booster Club, which sponsors athletics in Denton High School. He was a past president of the Denton Kiwanis Club, a member of the executive council of Boy Scouts, a steward in the First Methodist Church, and a member of the Shrine.

Miss Kenneth Wilson and Dr. Hinkle were married in Dallas on May 16, 1936. He is survived by his wife; two sons, Bill and Dan of Denton; one brother, C. M. Hinkle, Fort Worth; and two sisters, Mrs. H. H. Jenkins, Dallas, and Mrs. J. R. Hamm, Terrell.



DR. GEORGE W. HINKLE